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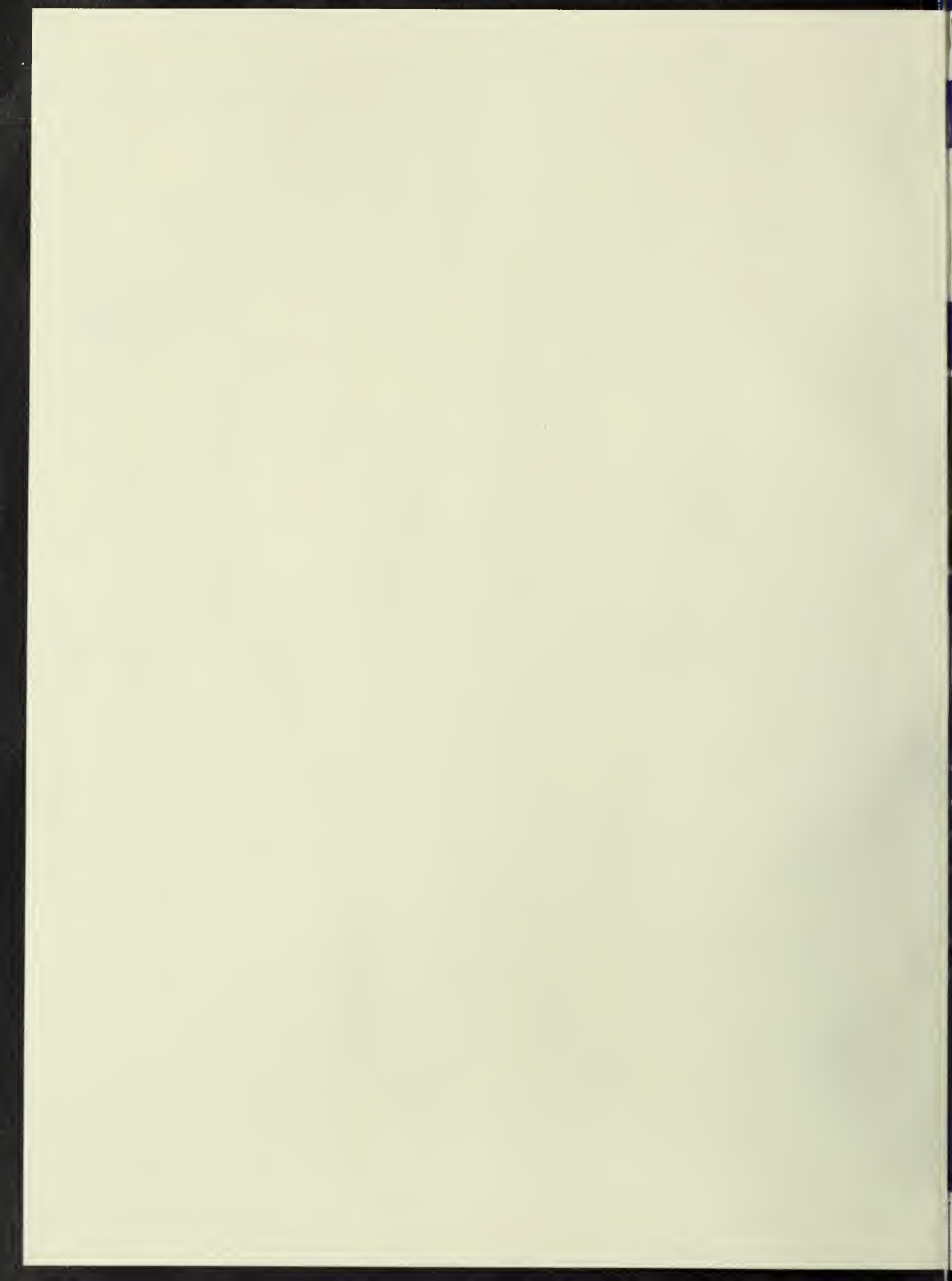


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Changing Minds Bulletin



The Massachusetts Department of Mental Health

Vol. No 18 Fall/Winter 1999-2000

From the Commissioner

Surgeon General's Report Promotes Treatment, Elevates Fight Against Stigma

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Mental illness affects one in five Americans each year. Twenty-two percent have diagnosable mental disorders. Half of all citizens experience such disorders at some point in their lives. Four of the 10 leading causes of disability for those ages 5 and older are mental disorders. In established market economies, mental illness is the second leading cause of disability and premature mortality. Mental disorders collectively account for more than 15% of the overall burden of diseases from all causes and slightly more than the burden associated with all forms of cancer. In 1996, the direct treatment of mental disorders cost the nation \$69 billion.

The data is endless.

Yet most people never seek treatment because of ignorance, fear of discrimination, stigma and lack of insurance. Many do not realize effective treatment exists, or they fear the consequences that reaching out for help will bring.

In the first ever U.S. Surgeon General's Report on Mental Health, David Satcher, M.D., points to the cruel and unfair stigma attached to mental disorders that prevail in an otherwise enlightened age. "Mental disorders are not character flaws, but are legitimate illnesses that respond to specific treatments, just

as other health conditions respond to medical interventions ... Stigma erodes confidence that mental disorders are valid, treatable health conditions ... Stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services ... Stigma tragically deprives people of their dignity and interferes with their full participation in society. It must be overcome."

The report's import underscores the Surgeon General's commitment to attack stigma that in many instances blocks an

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Surgeon General's Report (con't)

individual's willingness to seek treatment. The stigma "attached to mental illness is inexcusably outmoded" and must no longer be tolerated, the report states. Dr. Satcher underscores that what drives the stigma is the misguided perception that people with mental illness are prone to commit violent acts.

Dr. Satcher's report is a gift, an opportunity, a positive call to action. For more than 150 years, our country has had Surgeon Generals, the nation's doctors. They have issued 51 reports, all coming in the last 35 years. The majority have dealt with cancer and smoking. This 51st report is on mental health, acknowledging that it is fundamental to health, that psychiatric disorders are real illnesses. "Even today, everyday language encourages a misperception

that mental health or mental illness is unrelated to physical health or physical illness.

In fact the two are inseparable." It notes that research has provided effective treatments and service delivery strategies for many mental disorders.

The 450-page comprehensive report cites people deterred from seeking treatment for mental illness because they have no health insurance, their insurance does not adequately cover the costs or they have an "unwarranted sense of hopelessness" about the prospects for recovery. Mental health insurance "parity legislation has been a partial solution to this set of problems. Implementing parity has resulted in negligible cost increases where the care has been managed."

Mental illness is an equal opportunity disease. It ignores issues of socioeconomic status, gender, ethnicity and political party. Yet it is still spoken of in whispers, like cancer was 40 years ago

and AIDS was 25 years ago. Fingers are pointed in blame, even within the mental health community. Voices are seldom unified into a collective call to arms when it comes to addressing disparities of service availability and access to mental health care. What is true nationally is true in Massachusetts. The mental health field is plagued by disparities in the availability of and access to services. A key disparity often hinges on a person's financial status. This is why parity is so important.

So often we must try to create an opportunity out of a negative since the media generates so few positive stories about people with mental illness. Too often we only see or hear about mental illness as it is portrayed by Hollywood scriptwriters, novelists, columnists. We seldom hear or read about the many

people whose treatment and recovery have allowed them to be productive citizens.

Mental Illness affects one in five Americans in each year ... In 1996, the direct treatment of mental disorders cost the nation \$69 billion.

But people pay attention when the Surgeon General speaks. State mental health directors on hand December 13 when the report was released in Washington, D.C., certainly did.

Dr. Satcher's report gives stature and provides legitimacy to what many of us have believed in and worked on. Now there is an incredible national platform to stop treating mental illness as a stepchild, to bring treatment into the mainstream of health care. We must seize the moment, speak with a unified voice, and make something positive happen. We must work together towards the goal rather than compartmentalizing the issues. It is only through educating ourselves and others that we will have a well organized and financed mental health system in the Commonwealth and across the country.

SAFE **SCHOOLS**
HEALTHY **STUDENTS**
INITIATIVE

When President Clinton announced more than \$100 million to communities to prevent youth violence, the grant mandated involvement of a local mental health authority. The city of Springfield went to work and asked the Department of Mental Health to be one of its core partners in seeking the grant. Phyllis Birmingham, MSW, Director of Child and Adolescent Services in the Massachusetts DMH Office, met during the past summer with representatives of the District Attorney's office, the Superintendent of Schools, the Chief of Police, the Parks and Recreation Department and local DMH providers.

Springfield is one of 54 communities nationwide to receive a federal grant to help link public schools with community-based services and activities intended to make schools safer and protect young people from aggressive, violent behavior and drug and alcohol abuse.

Under the Safe Schools/Healthy Students Initiative, the Springfield school system has received more than \$2 million to design and implement comprehensive, educational, mental health, social service, law enforcement and juvenile justice services for youth. The project is an effort of the U.S. Departments of Education, Justice and Health and Human Services. Secretary of HHS Donna Shalala, said, "We need to nurture the personal strengths of children and adolescents so they can resolve problems without resorting to violence, drugs and suicide. We must enter the 21st century using the knowledge we have to promote healthy development among our children and provide prevention and treatment services for them."

Implementation of the initial steps of the program is underway. The final meetings were intense with the energy of a team eager to meet the challenge. Birmingham says there is such "excitement, electricity and possibilities in the air" that makes the Safe Schools/Healthy Students Initiative one of the most rewarding and promising projects of her career.

To learn more about how to make our schools safer, send for the booklet, "Early Warning, Timely Response: A Guide to Safe Schools" 1-800-872-5327.

EMERGENCY INTERPRETER SERVICES

The Massachusetts Commission for the Deaf and Hard of Hearing has expanded services for medical, mental health and legal emergency interpreter needs. This 24-hour service is available for emergencies at 1-800-249-9949.

For non-emergency needs, call the Interpreter Referral department of the Commission at 1-617- 695- 7500 or 1-617-695-7600 (TTY).

A First: National Summit of Mental Health Consumers and Survivors

This unique, first-ever event, sponsored by consumer/survivor groups from throughout the country, occurred last summer in Portland, Ore. The Key, a mental health consumer's newsletter, called the Summit "a preliminary step in creating a unified national voice."

Attendees found that on important issues they agreed more often than not, exploring together such thorny subjects as discrimination, ECT (electroshock therapy), housing and vocational opportunities. Sessions targeted strategies on organizing, testifying before the legislature and reaching the media with their "story."

Howard Trachman is a member of M-Power, the DMH Consumer Council, and the Metro-Suburban Board. He attended the National Summit and prepared this report.

By Howard D. Trachtman

I attended the National Summit of Mental Health Consumers and Survivors due to the financial support of the following: DMH, the Massachusetts Behavioral Health Partnership (MBHP), the Center for Mental Health & Retardation Services, and the South Middlesex Opportunity Council (SMOC).

The conference was organized by one of the three federally funded technical assistance centers, the National Mental Health Consumers' Self-Help Clearinghouse in Philadelphia, Pa. There were a number of co-sponsors of the conference as well. Originally, there were 11 planks to be discussed; at the request of many consumers a 12th plank was added. The planks dealt with: Advocacy, Organizing, Force and Coercion, Financing, Alternatives, Recovery, Stigma, Community Support Systems, Research, Forensic Issues, Multicultural Issues, and the 12th plank:--Accountability. Background information on each plank was available on the website of the clearinghouse at www.mhselfhelp.org. The idea was to try to create a national agenda for the consumer/survivor movement. I believe that we succeeded.

Participants were encouraged to attend only one or two of the groups discussing the planks in order to focus more in detail on the issues involved. I attended the Force and Coercion plank. We agreed at the beginning to try to reach decisions by consensus. We were treated to a brief presentation by Bazelon Center personnel and then worked together to reach consensus on issues. The group was against involuntary treatment of any type, inpatient or

outpatient. The group also rejected the use of restraint and seclusion.

The next day I attended a different plank. I chose Alternatives, which refers to peer-run services. Although I didn't have the background that others had, I was still able to participate and be effective. This plank chose not to work by consensus, but rather by hand signals to express one of three states: thumbs up for support, thumbs down for reject, or a signal to represent "I can live with it." We focused on the following questions:

What is the best way to document the effectiveness and value of alternative services to ensure their funding and continuity?

Should alternative services consider establishing program standards and staff certification/credentialing requirements in order to adapt to managed care and the possible concerns of public funders?

There were several opportunities throughout the conference for each plank's facilitators to inform all participants about what was being discussed and agreed upon. Each group took copious notes. They are available to everyone (not just conference attendees) on the clearinghouse website, www.mhselfhelp.org. We generated a lot of excitement and energy at the conference and want to be sure that the momentum continues to build. There was talk of having such a conference every year!

HAPPENING IN MASSACHUSETTS

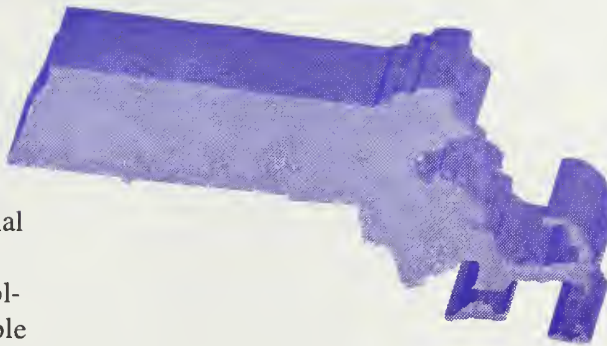
CLARIFYING THE BRAIN VS MIND CONTROVERSY: Three scientists took a new look at the old nature/nurture divide in an article published in the journal *Neurology*, January, 2000. Harvard Medical School neurologists Dr. Bruce Price and Dr. Raymond Adams and psychiatrist Dr. Joseph Coyle suggest that "two disciplines working together give far more hope than continuing these old turf wars." Fueling that battle was a difference in thinking about what causes disease. The latest science points to the biological aspects of psychiatric illness. "Brain vs. mind...it used to be either/or. It's really both," said Dr. Price.

CITED: Massachusetts Mental Health Center researcher and Harvard Professor of Psychiatry Dr. Carl Salzman, for his substantial contributions in clinical geriatric psychopharmacology. At a closed roundtable discussion "Treatment of Depression in Long-term Care Patients," Dr. Salzman's colleagues said of him, "He has shown us that it is possible in the nursing home setting to conduct systematic studies while also doing a great deal of good for patients. He is a role model and a pioneer in generating interest in geriatric psychopharmacology among psychiatrists and emphasizing that the frontier is very much at our doorstep."

QUESTIONS AND ANSWERS: In response to the new service planning regulations issued July 1, 1999, which define how and to whom DMH will provide services, a pamphlet is now available entitled "Service Planning for Adults, Children and Adolescents." Commissioner Marylou Sudders says, "The goal of service planning is to identify the full range of services a client needs, to facilitate or provide access to these services and to ensure that continuing care is consistent with a client's needs and preferences and is provided in the least restrictive setting possible." This booklet will help people in need of services and their families and physicians

understand how to access appropriate care. To receive a copy of call 617-626-8130.

HEAR US: From its green marble panel on the State House wall, a bronze bust of Dorothea Dix proclaims to passersby, "I tell what I have seen." This new art honors the work and words of six women who changed Massachusetts government. Responsible for the removal of "insane convicts" from state prisons in 1844, Dix was an early advocate for humane treatment of the mentally ill. The busts of five other women, all champions of justice, share with Dorothea Dix this historic space under the gold dome on Beacon Hill.

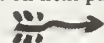


SPPEAKING THE LANGUAGE: "Although some observers may regard cultural competence as an unnecessary frill, it is a key element in successful treatment outcomes." ("Cultural Competence in

Medicaid Managed Care Purchasing,") Only Massachusetts and Nebraska Medicaid contracts require, with clear instructions and performance measures, that providers be proficient in the language spoken by enrollees. Massachusetts further facilitates the dissemination of informational and educational materials with its multilingual brochures and newsletters. For more information, call Ed Wang, Ph.D., Director of Multicultural Affairs at 617-626-8137.

YOUR ROLE IN SAFE MEDICATION USE: A GUIDE FOR PATIENTS AND FAMILIES: A pamphlet prepared by the Massachusetts Coalition for the Prevention of Medical Errors is now available and has been distributed to hospitals, health centers, pharmacies and libraries across the state. It will help you become an active and informed member of your health care team and ensure that medications prescribed for clients and families are properly used and understood. Members of the Coalition include the Massachusetts Department of Public Health, Harvard Risk Management Foundation, Boston University School of Medicine

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and the Massachusetts Medical Society. The brochure is available online at <http://www.mhalik.org> or by calling 781-272-8000, ext.276.

CONSUMER SATISFACTION: In face-to-face interviews with consumers and their families, the Massachusetts Behavioral Health Partnership is gathering information that will be used to identify ways to increase satisfaction with services. The Partnership, in conjunction with the Division of Medical Assistance, will evaluate mental health and substance abuse services provided through at least 30 inpatient, day treatment and partial hospitalization programs. For more information, call Johnathan Dellman at 781-246-5329.

New Schizophrenia Guidelines Designed for Clients, Families

In an effort to foster communication between clients, families, and clinicians, DMH has recently released new, easy to use booklets summarizing the guidelines for the treatment of schizophrenia in adults. The booklets, which have begun to be distributed, are designed to simplify information on living with schizophrenia and are modeled after the larger guidelines given to clinicians.

Commissioner of DMH, Marylou Sudders, saw the need to better inform clients and their loved ones of the nature of schizophrenia. "Mental health professionals had a guide to treating individuals with schizophrenia written in their clinical language but to the client and his family, the guide was, at best, hard to understand. We needed to put that same information that is so vital in understanding this disease into layman's terms," she said.

The pamphlet outlines several important issues that affect those with schizophrenia on a daily basis. The causes, symptoms, and effects of schizophrenia are put into terms that are understandable by the general population. The booklet contains clear information of how antipsychotic medication may work and what their side effects might be. It also points out some general considerations regarding schizophrenia that may prove helpful when talking to a clinician.

For more information on [A Summary of Clinical Practice Guidelines for the Treatment of Schizophrenia](#), call Nancy Secley at 617-626-8118.

M-Power Conference Brings 400 Together To Lay Groundwork For "Real Recovery"

By Steve Holochuck

"Don't just imagine care, let's make real recovery happen," Yvette Sangster, Executive Director and founder of Advocacy Unlimited, recently told mental health consumers, psychiatric survivors, staff, family members, and friends gathered in Sturbridge for the Imagine Care: Real Recovery I conference.

Sangster, a dynamic speaker, interacted with an audience of about 400 individuals last month in an "Oprah Winfrey" television show format. She engaged those on hand in a dialogue concerning consumer needs, preferences and perspectives. She was greeted with passionate responses ... "we need jobs and affordable housing" ... "we want more funding for peer support and consumer-run programs" ... "why can't consumers have access to alternative treatments?"

"We want more funding for peer support and consumer-run programs ... We need jobs and affordable housing"

Sangster emphasizes that the only way to reach such goals is to take the thousands of individual consumer voices and bring them together in a strong, skillful, statewide advocacy organization. She asked the audience for a show of hands signifying advocacy. She invited them on stage, asked how many people might not consider themselves advocates but had done something that they considered advocacy. She invited them to the stage as well. Sangster progressively brought more and more people from the audience onstage to concretely show the power of building a united mental health consumer/survivor/cx-patient network.

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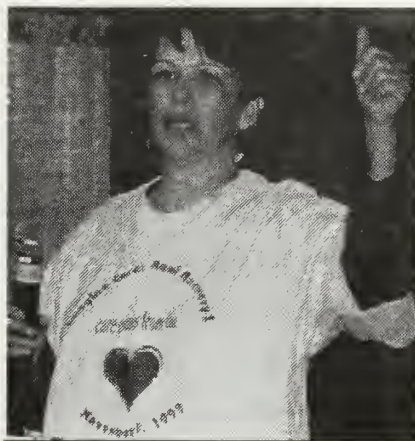


Real Recovery (con't)

The day-long conference was presented by Massachusetts People/Patients Organized for Wellness, Empowerment, and Rights (M-POWER), which is under a contract with DMH.

Department of Mental Health Commissioner Marylou Sudders, who delivered opening remarks, emphasized the right of consumers to full human rights, dignity, and a high quality of life. She spoke of her vision of a mental health system that stresses services utilized on a voluntary basis and includes peer support. Examples of consumer/survivors working together to transform a dream into reality also were offered by the DMH Office of Consumer and Ex-Patient Relations.

Consumers came together in various workgroups, which will serve as "launching pads" for ongoing networking, organizing and advocacy regarding specific constituencies and issues. The workgroups focused on diversity, board and committee membership, self help and peer support, the arts, legislative advocacy, consumer-run projects, fundraising, communications, spirituality, quality of life, alternative approaches to psychological distress and consumers who work in the system. Participants engaged in animated discussions, making the most of the opportunity to meet with others from across the state who share common experiences and concerns.



Yvette Sangster, Executive Director of Advocacy Unlimited, emphasizes a point during her keynote address at the statewide consumer conference.

ence, large numbers of conference participants enthusiastically shared their needs, hopes and aspirations regarding services and supports for the future: "No more restraint and seclusion"... "can't we all be accepted as people like everyone else?"... "I want to see a strong consumer/survivor organization in Massachusetts with support and advocacy groups in every city and town."

Conference participants left with a T-shirt which helped to sum up the day's activities. The front carried the message, "Real care comes from the heart." The back was topped by the slogan of the South African cross-disability movement: "Nothing about us without us!" The Massachusetts consumer/survivor movement has adopted the slogan. Underneath is a logo containing a circle of reaching hands in diverse colors. At the bottom is: "Lend a helping hand to empowerment!" The conference was funded by the Department of Mental Health.

Steve Holochuck is Director of the Office of Consumer and Ex-Patient Relations at the Department of Mental Health.

Anyone interested in more information on related consumer/survivor activities throughout the state may contact M-POWER, 518A Dorchester Ave., Boston, MA 02127, Telephone 617-464-1400, e-

mail: info@m-power.org, Website: <http://www.m-power.org>.

In the closing session, Linda Stein, a statewide leader, invited consumers to get involved in upcoming organizing activities such as the statewide consumer planning team and the larger planning congress. She also encouraged them to fill out the conference survey that requested information concerning areas of individual interest and ability. As microphones were again passed through the audi-

Correction:

Due to an editing error, "It is the Springtime of My Life" by Bonnie Twomey (vol.17,1999) incorrectly portrayed the author's ability to cope with mental illness. It should have said, "Most of the time, I just do not know how I cope."

Department of Mental Health Employees, Groups Honored

Twelve individuals and three groups received Commonwealth Citations for Outstanding Performance at the annual Performance Recognition Awards dinner at the Hynes Convention Center. Governor Paul Cellucci delivered the keynote address.

The DMH award winners and those from other state agencies helped departments and divisions reach priority objectives. They demonstrated organizational, managerial, or communications skills, exemplary leadership, and helped to make significant improvements in productivity or realize substantial savings in agency operations.

Two of the awards were given posthumously. The late Paul Cozzens, a long-time mental health worker at Westboro State Hospital, died December 10, 1998, when he was crossing a street at Taunton State Hospital just after his shift had ended.

The family of Richard Silvia, another veteran mental health worker who died last year, accepted the award on

his behalf. Silvia drowned as he was attempting to save a 14 year-old boy who had fallen through the ice. As Silvia struggled to rescue the child, the ice gave way and he crashed into the frigid waters. Silvia managed to push the boy to the edge of the ice where firefighters later rescued him. Silvia could not stay afloat.

Silvia also received one of 20 national awards presented by the Carnegie Hero Fund Commission for heroism. The Carnegie Award was the most recent in a series of honors memorializing Silvia which include scholarships given to DMH employees in his and Cozzens' names and a road race, "Run for Ricky."

In addition to Silvia and Cozzens, the Performance Recognition Award winners of DMH included: Susan Scola, Vielca Rivera, Lawrence White Jr., Rosita Monroy-Barber, William Foreman, Donna Ulman, David Potter, William Scott, Robert Smith, Lynda Plasse, DMH AIT Infrastructure Leadership Group, Metro-Boston Painting Crew, and Western Mass. Management Curriculum.



Susan Scola
Central Mass. Area



Western Mass. Case Management Curriculum
Committee members Diane Versace,
Peg O'Brien, Harry Weinmann



Vielca Rivera
Central Mass. Area



AIT Infrastructure Leadership Group
Larry Hookey, John Sherwood, Commissioner Sudders, Judy Rygiel, and Janine Paquette

at State's Performance Recognition Awards Ceremony



David Potter
Northeast Area



**Lou Ann Silvia, Commissioner Sudders,
and John Silvia**



Donna Ulman
Metro Suburban Area



Robert Smith
Northeast Area



Dennis Roland and Charles Montgomery
Metro Boston Painting Crew



William Scott
Northeast Area

THE CHANGING MINDS BULLETIN

A quarterly publication of the Massachusetts Department of Mental Health, reporting state news and relevant information for clients and their families, mental health professionals, vendors of services, and all citizens interested in the goals and mission of this human service agency.

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RAISING AWARENESS ABOUT MENTAL ILLNESS



GETTING IT RIGHT

HOLLISTON HIGH SCHOOL: Joining eight other high schools across the country, Holliston High School administered a test last fall with no right or wrong answers. The Depression Screening Survey, voluntary and self-scored, aims to help the 5% to 8% of teenagers estimated to be clinically depressed. Students answered 27 questions - Do you feel hopeless? Have trouble concentrating? Feel sad? Contemplate suicide? The questionnaire included names and telephone numbers to call for support. In a state behavior survey taken by Holliston students last year, one-quarter of them said they had experienced suicidal thoughts and 12% reported they had tried to kill themselves. Suicide is the third leading cause of death among 15-24 year-olds nationally.

BOSTON UNIVERSITY CENTER FOR PSYCHIATRIC REHABILITATION: "People with serious mental illness are able to succeed in responsible, stressful, well-paid positions," said Marsha Ellison, senior research associate at the center. A study surveying 500 individuals with severe psychiatric conditions found that 73% reported full-time employment, 62% have held their current position for more than two years and 88% were taking psychotropic medications. Zlatka Russinova, co-author of the study, acknowledges that "having a mental illness is a challenge," but hopes this study will spur an "attitude change."

GETTING IT WRONG



DON FEDER, syndicated columnist, Boston Herald: Concerning efforts by mental health organizations to register individuals with mental illnesses and their families to vote in year 2000 elections, Feder wrote, "Give me your schizophrenics, your paranoids, your manic depressives - for what?"

Ironical that the same week Feder wrote it was "absurd" for people with mental illness to vote, Boston University released its study showing that many people with mental illness work full time (see above). Would Feder bar them from the voting booth? How about Tipper Gore and Barbara Bush? Has he noticed that mental illness is non-partisan?

MIKE BARNICLE: During Barnicle's talk-radio debut, he chatted with guests from politics, sports and the media. He interviewed presidential candidate John McCain and Jeremiah Burke High School Headmaster Steven Leonard. But this host did not care to hear from the listening public, referring to talk-show callers as "inmates in mental asylums."

AND, A CHANGE



OF MIND...

NESTLE USA: "Psycho Sam," Looney Jerry" and "Weird Wally" are taffy bars? Nestle says the names "amuse children and are rooted in a silly, playful humor." Rosalyn Carter disagreed. So did the National Alliance for the Mentally Ill (NAMI.) Their objections prompted Nestle management to rethink its marketing plan and discontinue the offensive names. The explanation: "We change business strategies based on consumer preferences and marketplace trends." Message #1: mental illnesses are not silly, playful or humorous. Message #2: Minds can be changed.

MGH and DMH - Partners in Research at Freedom Trail Clinic

The Schizophrenia Program of the Massachusetts General Hospital combines an outpatient and clinical teaching program at the Freedom Trail Clinic located at the Eric Lindemann Mental Health Center in Boston. Research there is focusing on new treatment approaches and a Wellness Program to assist with smoking cessation, weight reduction and prevention of diabetes in people with schizophrenia.

Members of the Schizophrenia Program are available to consult with individuals with schizophrenia and their families regarding treatment options and investigational studies. Consultations can be arranged by calling the Freedom Trail Clinic at 617-912-7800.

The following report describes one aspect of the Wellness Program.

Promoting Wellness Through Weight Control: Adapting What We Know about Weight Loss To Individuals With Schizophrenia

By Cori Cather, M.A.

Obesity is a national health problem on the rise. Obesity-related medical expenses account for nearly 7% of the nation's total medical costs. Current estimates indicate that 18% of the U.S. population is obese; rates are higher among individuals with lower incomes. Prevalence rates among individuals with schizophrenia are similar to the general population, although data suggest that women with schizophrenia are heavier on average than women without mental illness. Because weight gain is associated with chronic medical illnesses, decreased quality of life, and poor adherence to medication regimens, it is of special concern in the severely mentally ill. However, to date, weight loss treatments have not been studied in this population. Cognitive-Behavioral Therapy (CBT) is an established psychosocial treatment for weight loss that is being adapted as part of a multidisciplinary treatment of obesity for individuals with schizophrenia at the Freedom Trail Clinic.

Why Worry About Weight Gain?

In the general population, obesity is associated with increased risk for a wide variety of medical problems including: diabetes, coronary heart disease, hypertension, gall bladder disease, osteoarthritis, respiratory disease, and certain cancers. Similarly, among the seriously mentally ill, medication-induced weight gain has been implicated in both new-onset cases and the exacerbation of previously well-controlled diabetes. As a result, routine blood glucose monitoring has been suggested for patients who take newer antipsychotics, especially among individuals with a family history of diabetes. Additionally, increased triglycerides, an established risk factor for cardiovascular disease, have been found in patients taking newer antipsychotics. Antipsychotic agents appear to increase the tendency towards abdominal body fat deposition (the "apple" body shape), which is troubling because this pattern of weight gain is associated with increased risk of cardiovascular disease.

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Wellness Through Weight Control

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What is the Relationship Between Antipsychotic Drugs and Weight Gain?

Tremendous benefits have been derived from the advent of the newer antipsychotic drugs and these medications are essential in the treatment of schizophrenia. However, weight gain is an unfortunate side effect of many of these medications. Of particular concern is the fact that weight gain prompts some individuals to discontinue taking their medication, resulting in a worsening of symptoms. Most weight gain occurs early in treatment and levels off after 1-2 years on the drug. Interestingly, progressively higher doses of these agents are not associated with greater weight gains. How these drugs promote weight gain is unclear, although, leading biological hypotheses suggest that the mechanism involves neurotransmitter, hormonal, and/or glucose regulation. Perhaps as a result of the biological changes, these drugs may alter eating behavior and activity level in ways that increase weight. Patients report increased appetite on antipsychotic drugs and do not experience a sense of satiety after consuming a meal. Drugs which produce dry mouth can lead patients to consume large quantities of calorie-containing beverages. Thus, it could be that one explanation for the increased weight is an increase in caloric consumption. Additionally, the sedative effects of the medication may operate to decrease activity level, resulting in lower energy expenditure and weight gain.

What are the components of a Cognitive-Behavioral Approach to Weight Loss?

CBT is an active, focused treatment that

targets the modification of eating and exercise behavior as well as self-defeating thoughts. CBT includes the following components: setting a reasonable goal weight, self-monitoring, problem solving, nutritional education, limiting food exposure, decreasing the rate of eating, cognitive restructuring, and developing an exercise program. In early sessions, a focus is to

set a reasonable goal weight.

Setting a reasonable goal weight is a critical part of establishing realistic expectations for treatment. This is important because people have a tendency to set too high of a weight loss goal.

Moreover, weight losses of only 5-10% have been found to be associated with meaningful health benefits. Individuals also learn to keep track systematically of foods, times of day that eating occurs, emotions associated with eating, and exercise habits. This form of record keeping increases

awareness of eating behavior and identifies high-risk situations. Often, individuals find that negative mood states (like boredom or anxiety) increase eating. This treatment assists the individual to develop other ways of responding to and coping with negative moods besides eating. Problem-solving skills assist individuals to respond in an optimal way to challenges faced in developing and maintaining a healthy eating and exercise regimen. Nutritional information is incorporated in order to stress the importance of eating a variety of foods on a regular schedule in the context of a low-fat diet. Limiting food exposure builds skills to control the food environment through planning. Similarly, strategies to decrease eating rate function to maximize satiety and minimize caloric intake. Cognitive restructuring targets self-defeating thoughts related to one's body image, ability to make changes in eating and exercise, and interpretation of dietary lapses.

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Wellness Through Weight Control

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How Well Does CBT Work for Obese Individuals Without Psychiatric Illness?

In combination with moderate caloric restriction (1,200-1,500 calories per day), these interventions have been found to produce an average weight loss of approximately 20 pounds in five months at a rate of approximately 1 pound per week in obese individuals. Losing 1-2 pounds per week is considered a healthy rate of weight loss. Although CBT is promising with respect to short-term weight loss, its results in terms of long-term maintenance have been disappointing. As many as 95% percent of patients who successfully lose weight through these programs regain the weight after five years. This has prompted researchers to identify the factors that promote successful maintenance of weight loss. Continued contact with a treatment provider as well as persistence in an exercise program have been identified as the factors most strongly associated with better long-term outcomes.

How Can We Adapt CBT For the Severely Mentally Ill?

Adapting CBT to individuals with severe mental illness presents certain challenges. Due to the confounding effects of medication, reasonable weight must be assessed in the context of medication history. Some individuals may find traditional self-monitoring too detailed to be useful. In this case, modifications are needed to include the elements of record-keeping that are most essential. Another difficult aspect of applying these treatments to this population involves the individual's limited ability to alter the food environment. Many severely mentally ill do not live indepen-

dently and therefore, are not the primary decision-makers about which foods are available to them. Moreover, as a result of limited income, many will choose pre-packaged foods that are cheap, easily accessible, and high in fat/calories. Exercise regimens may be difficult to implement because of illness symptoms (e.g., avolition) as well as discomfort with exercising in public. Importantly, these treatments will have to be sensitive to their influence on symptoms of mental illness and their acceptability to the individual.

Although the limited long-term efficacy of these interventions must not be overlooked, it is possible that these outcomes will in fact be

Weight losses of only 5-10% have been found to be associated with meaningful health benefits.

better in individuals with severe mental illness. One of the best predictors of weight loss maintenance is continued contact with weight loss treatment providers. Treatment of mental illness requires long-term

contact with a health care professional; this provides the opportunity for adjunctive weight treatment. These booster sessions can be aimed at reversing small weight gains and helping patients get back on track. Comprehensive treatments should aim to work in conjunction with staff at supervised living environments, as well as with families, to adapt menus and eating patterns. The most important lesson gained from applying weight loss interventions in the general population is that these interventions must be delivered in the spirit of managing a chronic condition.

Corinne Cather is a Clinical Fellow in Psychology at Harvard Medical School and Massachusetts General Hospital. She is a clinician and researcher studying the use of CBT in individuals with schizophrenia at the Freedom Trail Clinic at the Erich Lindemann Mental Health Center in Boston.

Stop Stigma

DISCRIMINATION AFFECTS YOUTH

The tragedy of Columbine, the sight of children being tried and convicted as adults in our courts, reports of drug and alcohol incidents among teens, the prevalence of depression and suicide among young people, have led to calls for increased mental health services for children and adolescents. But even when such services are available, children and parents often fail to make use of them.

Young people misunderstand and fear mental illness and the mentally ill. Children learn early on that these illnesses are viewed as failures of character and will. Even second and third graders appear to have caught on to the idea that it is acceptable to disparage some people as "crazy," "nuts" or "insane." They hear adults complain about someone driving like a "lunatic" or acting like a "madman." They quickly understand that it is embarrassing and shameful to be diagnosed with a psychiatric problem.

The media confirms their suspicions. The heroes in the movie, *Good Burger*, based on a popular Nickelodeon series, Keenan and Kel, encounter unkempt psychiatric patients at the Demented Hills Asylum who growl at visitors and eat the deuces to aces in a card game. For older kids, a chart-topping MTV video ("I Drive Myself Crazy") by the music group N'Sync shows spaced-out patients in straight jackets and padded cells.

Is it any wonder that children resist admitting to emotional problems? How can even the most caring and enlightened parents reassure children that counseling or medication will help? To ensure that more and better mental health services are available and that children and families use them, stigma must be confronted.

Tipper Gore said, "If we are serious about stopping the violence and helping our children, adults need to erase the stigma that prevents our kids from getting the help they need for their mental health."

WHERE ARE THE STIGMA-BUSTERS?



Many individuals and organizations are trying to reduce the stigma of mental illness. They include the National Mental Health Association, the National Alliance for the Mentally Ill, the National Stigma Clearinghouse, the international Rotary Club "Erasing the Stigma" project, the National Empowerment Center and the Changing Minds Campaign of the Massachusetts Department of Mental Health. All share

the goal of increasing the understanding of mental illnesses as no-fault, biologically based diseases that are experienced by one in five people Americans each year.

Since 1990, the all-volunteer National Stigma Clearinghouse has been focusing on inaccurate images of mental illness in news, advertising and entertainment media. It maintains a clippings and articles file on stigma and related topics. It furnishes this information upon request to consumers, families, mental health organizations and professionals in the field.

"Erase the Stigma (ETS)" is designed to educate the public about the pervasiveness of mental illness and successful new treatments for it. Started in 1992 by members of a California Rotary Club, it brings the message of recovery and rehabili-

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Stigma Busters

from previous page

tation to Rotarians and assists them in hiring individuals who have been denied the opportunity to be productive citizens.

The Changing Minds campaign was launched by DMH in 1997 with public service announcements by Tipper Gore and Mike Wallace. The campaign released a report on a statewide opinion survey indicating that 90% of the public believes that mental illness is so stigmatizing that treatment is often avoided. The survey found that

Campaign to End Discrimination

lack of information — and misinformation — are the principal reasons why people do not see mental illnesses as diseases of the brain, in the same way they understand that arthritis is a disease of the bones and joints. The Department of Mental Health continues to raise awareness about mental illness through its publications, brochures, a free video library and outreach efforts such as its support of the Massachusetts NAMI Family to Family education program.

Stigma is beginning to be recognized for the added burden it is for people with mental illness and their families. But it is just the beginning. The Surgeon General has moved the issue into the spotlight. Research looks promising. Eliminating stigma is essential.

For more on information on these programs or ways for you to help fight stigma, call the DMH Public Affairs Office: 617-626-8157.

NATION'S NO.1 HEALTH CARE CONCERN

A Newsweek poll to determine what health care issues matter most to Americans found that long-term care worried more people than the troubled managed care industry. Only the high costs of health care itself and spiraling prescription prices raised more concern.

"Long-term care" conjures up images of the elderly, but this is only part of the picture. Of those needing long-term care, 40% are younger persons with disabilities. The lack of a comprehensive long-term care system in this country has spawned the Long-Term Care Campaign, a non-profit, non partisan coalition of 150 organizations.

Jon Dauphone, executive director of the campaign, points out that the poll indicates widespread concern about this issue. Thus, the campaign is pushing presidential candidates to spell out what they would do about long-term care.

Vice-President Gore and former Senator Bradley, have signed a pledge promising leadership on the issue. As the campaign steps up pressure on all candidates to address the need for answers, long-term care promises to be an important part of the debate.

Some facts:

- ◆ One third of the homeless are mentally ill;
- ◆ Two-thirds of persons with mental illness live with aging parents;
- ◆ Community services often overlook the needs of the mentally ill;
- ◆ The present death rate is significantly higher for many mentally ill individuals than for the general population, indicating greater need of support services.

For information: Long Term Care Campaign, Box 27394, Washington, D.C. 20038, 202-434-3744; info@ltccampaign.org; www.ltccampaign.org.

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From the Commissioner

Mental Health Parity at Last

By Marylou Sudders

John Willett is a father with a 15-year-old son whom he dearly loves. The teenager, Michael, has a deep-seated illness, which if left untreated often results in death. Medical treatment is available, but strings have been attached.

"Unfortunately for Michael, the psychotherapy visits that are as vital to his survival as dialysis is for individuals with kidney disease were limited to eight per year," Willett says in looking back on many yesterdays. "Can you imagine the emotional and financial anguish that a cap

on dialysis treatments would impose on the families of those patients with kidney failure?"

The Pepperell father of three was speaking about discriminatory insurance coverage practices that artificially imposed caps on treatment of people with mental illness. If Michael Willett needed dialysis, the family's insurer would cover his treatment. But since he has schizophrenia, Michael's uncovered outpatient treatments and

Parity continued on page 11



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Governor Cellucci hands the pen used in signing mental health insurance parity legislation to DMH Commissioner Marylou Sudders as Lieutenant Governor Jane Swift, family member John Willett, and others look on.

Cameos Make a Point as Duckworth Goes Hollywood



Question: What do Glenn Close, Aladdin, Faye Dunaway and Bill Murray have in common? Answer: They all have cameo appearances in Dr. Ken Duckworth's video, *The Stigma of Mental Illness*.

Duckworth is the new DMH Deputy Commissioner for Clinical and Professional Services. He is an outspoken advocate in the fight against stigma and discrimination associated with mental illness. His video is designed to increase the understanding of health care professionals concerning stigma. It shows how the media often stigmatizes people with mental illness through ridicule and stereotyping, even though science has proven that severe mental illnesses are biologically based brain disorders. The result is that people with mental illness face increased shame and discrimination in all aspects of life.

Dr. Duckworth, the recipient of awards from the National Alliance for the Mentally Ill and the Massachusetts Alliance for the Mentally Ill, recently testified at U.S. Senator Edward Kennedy's Congressional hearing on funding for mental illness. He spoke of his experiences as a family member and the need to increase education and financial support so that people with mental illness are no longer treated differently than those with cancer or heart disease.



Ken Duckworth with daughter, Katie.

Hollywood continued on page 10



Dr. Duckworth Goes to Washington

In what he described as "Mr. Smith's Day in Washington," Ken Duckworth, M.D., Department of Mental Health Deputy Commissioner for Clinical and Professional Services, recently testified before the U.S. Senate Committee on Health, Education, Labor and Pensions. Dr. Duckworth supported legislation introduced by Senators Pete Domenici and Paul Wellstone that would end discriminatory health insurance coverage for adults and children with severe mental illnesses.



Under the Domenici-Wellstone measure, full insurance parity would be provided for schizophrenia, bipolar disorder, major depression, obsessive-compulsive and panic disorders, autism and other disabling illnesses such as anorexia and attention deficit disorder. Insurers would be required to reimburse for treatment of these illnesses at the same level as that offered for other

physical conditions. This legislation also would eliminate the September 30, 2001, sunset provision of the Mental Health Parity Act of 1996.

The hearings began with a report from the Government Accounting Office (GAO) that the cost of implementing parity is minimal. Steven Hyman, M.D., Director of the National Institute of Mental Health, then outlined how science is advancing in the treatment of people with mental illness. The four panelists

Washington continued on page 10



DMH Extending Reach Of Changing Minds Campaign



Larson Joins Mauch as Co-Chair

Gloria Larson, a partner at the law firm of Foley, Hoag and Eliot and currently chair of the Massachusetts Convention Center Authority, has joined Danna Mauch as co-chair of the Department of Mental Health's Changing Minds Campaign.

Larson, who served as state Secretary of Economic Affairs, received a "Wonder Woman" award from the Massachusetts Women's Political Caucus in 1991 for her many federal and state achievements. She brings energy and expertise to Changing Minds, a Department initiative since 1997.

DMH Commissioner Marylou Sudders is committed to publicizing the message about rehabilitation and recovery of people with mental illness. It encompasses scientific breakthroughs in brain research, innovative approaches to treatment and includes the clear call for an end to the stigma often associated with mental illness.

The campaign is launching a new initiative, focusing on the increasing number of aging caregivers who are seeking assurances that family members will continue to receive appropriate treatment.

In this latest endeavor, the Department is joined by Catholic Charities, the Massachusetts Association of Older Americans (MAOA) and the National Association for the Mentally Ill of Massachusetts. A public forum on "Seniors as Principal Caregivers," sponsored by DMH and the legislature's mental health and elder affairs caucuses, is scheduled for September 13 in the Great Hall of the State House. The forum will be led by Representative Kay Kahn of Newton, chair of the Legislative Mental Health Caucus, and Representative John Rogers of Norwood, chair of the Legislative Elder Affairs Caucus.

On the horizon is a plan to emphasize children's mental health needs. Since May 1999, when Commissioner Sudders and Robert Macy, Executive Director of the Arbour Health Systems Foundation, addressed a meeting of state school superintendents, DMH has been holding information and training sessions with teachers and school administrators from across the state.

Changing Minds began in October 1997 with the release of results of a statewide public opinion survey. They indicated that 90 percent of the public believes mental illness is so stigmatizing that most people would avoid seeking treatment. Individuals would not tell friends or co-workers if they were experiencing symptoms or receiving treatment. In light of the findings, Sudders offered a plan revolving around a basic theme: mental illness is an illness, it is treatable and treatment works. What followed were a public service announcement featuring CBS-TV and 60 Minutes correspondent Mike Wallace, a radio spot from Leslie Stahl of CBS News, and a series of billboards, bus and train ads.

Commissioner Sudders appointed a 35-member task force to help shape the campaign, chaired by Charles Baker, head of Harvard Pilgrim Health Care and former state Secretary of Administration and Finance, and Mauch, President of Magellan Solutions.

Seeking to educate legislators about advances in the field of mental illness and to raise awareness of discrimination faced by people with mental illness, Sudders put on a series of informational legislative forums.

At the request of Representative Michael Cahill, House Chair of the Joint Committee on Human Services and Elderly Affairs, the most recent forum (July 19) helped members and staff to better understand biological brain disorders, stigma and how substance abuse complicates recovery.



Depression Screening Expands to Schools

Depression is a treatable mental illness, yet only a small percentage of individuals are accurately diagnosed and treated. In the worst case scenario, depression leads to suicide; in the best case, treatment and recovery occur.

Suicide is the third leading cause of death in the United States among young people between the ages of 15 and 24, and in Massachusetts, it is the second leading cause of death in this age group. A 1999 survey by the state Department of Education found that one in every five Massachusetts public high school students had seriously considered suicide in the previous year, and one in 12 – more than 20,000 teenagers – had attempted it.

Depression screening is important for all individuals; it is essential for teenagers. Screening for Mental Health (SMH) is a Massachusetts-based nonprofit organization that developed the model for community-based depression screening 10 years ago

with National Depression Screening Day. SMH has worked in all aspects of the community offering both depression screening and public education.

This year, SMH has teamed up with the Massachusetts Department of Mental Health, federal agencies, experts in the field – counselors and school psychologists, nurses, principals, and others – in an effort to offer a new suicide prevention program for high school students.

The program is designed to educate students about depression as well as suicide. Students should understand that depression is a treatable illness. They will learn to recognize signs of depression and suicidality. Students also will learn that they are in the best position to prevent a friend's suicide by telling a responsible adult about their concerns.

Participation in the program for the first few years will be limited to 500 schools. Further information is available by calling 781-239-0071.

Other depression screening projects include:

☉ **The Eating Disorders Screening Project**

was held for the first time on more than 600 college campuses February 5-11, 1996. Designed for college students, the program was expanded in February 1998 to include the general population. This year, screenings were available to high school students. The special materials produced to address eating disorders in young people were prepared with the help of the Massachusetts Eating Disorder Association, Inc., and the Children's Hospital Outpatient Eating Disorders Program in Boston.

☉ **National Alcohol Screening Day** debuted

in April 1999. This past April, anonymous screenings to address a range of behaviors from risky drinking to alcohol dependence were again offered. The program included an educational presentation, a written questionnaire, an opportunity to meet with a health professional and referrals were made where appropriate. The college component of Alcohol Screening Day targeted young adults with an emphasis on the problem of binge drinking. The Robert Wood Johnson Foundation funded this campus outreach in support of alcohol awareness.

☉ **Anxiety Disorders Screening Day**, May 3,

2000, reached out to the more than 35 million adult Americans whose lives are affected by these medical illnesses. They include phobias, panic attacks, generalized anxiety, obsessive-compulsive disorders and post traumatic stress syndrome. The program featured a video of Marc Summers, former host of Nickelodeon's *Double Dare* and author of *Everything in Its Place, Living Successfully with Obsessive Compulsive Disorder*. Parade, Newsweek, Time and Good Morning America previewed the event.

☉ **Depression Screening Day**, an important and

visible component of Mental Illness Awareness Week, will be held October 5, 2000. Again this year, it will call attention to depression and manic-depression, educating the public about symptoms and effective treatments. Of the 3,000 screening sites, 600 expect to offer screenings in Spanish. Beginning September 14, call **1-800-573-4433**. The phone is automated and the message will identify a screening site in your community. The neighborhood site will have information on screenings in Spanish.

HAPPENING IN MASSACHUSETTS

The Meadow Gardens greenhouse in Longmeadow nurtures plants and people in a garden shop that embodies its description: "a place where spirits grow."

Surrounded by lush tropical plants, (a specialty) aromatic herbs and a cheerful mix of colorful annuals and perennials, the staff goes about the usual business of cutting and potting, watering and weeding to produce the bounty that lures motorists from busy roads in Western Massachusetts. What is unusual about Meadow Gardens is that the workers suffer from schizophrenia, depression, bipolar and post traumatic stress disorders. Donna Cavagnac, a horticulturist and social worker, who supervises the greenhouse, does encounter one experience not often seen in most businesses: staff which sometimes comes in to help on a day off ... without pay!

One woman, who said, "I was very inside myself," loves to work with seedlings. Now there is a healing metaphor to hold on to.

The Boston Neighborhood Services Trauma Response Network, a coordinated initiative of the Department of Mental Health and Boston Mayor Tom Menino's Office of Neighborhood Services, trains community leaders to help young people deal with the trauma of violence and suicide, experiences all too common in urban settings. Since 1997, the time of an extraordinary number of suicides, networks have been assisting adolescents in Charlestown and South Boston.

A \$1 million grant from the Department of Mental Health and \$200,000 from the Boston Public Health Commission is enabling Boston's youth workers to provide the tools for coping with traumatic incidents witnessed by neighborhood children.

Restoration and maintenance work at gravesites at two cemeteries on the grounds of the former Danvers State Hospital continues. Landscapers have cleaned and upgraded the gravesites of more than 700 patients who spent their last days in this hospital, which was closed in 1992.

Restoring the cemeteries restores a measure of dignity and respect many did not receive during their lifetimes. It also helps to change attitudes toward mental illness and displaces some of the stigma associated with psychiatric disorders.

Nothing to Hide: Mental Illness in the Family, a photo and text exhibit established to educate and create awareness about the diversity that exists in families, was displayed in Northampton during the summer.



The exhibit, co-sponsored by the DMH Western Massachusetts Area, was presented by Family Diversity Projects, Inc., a non-profit educational organization. The exhibit includes photographs of and interviews with 20 families, some of whose members struggle with severe mental illness. These family portraits demonstrate strength, courage and accomplishment in the face of adversity and stigma. They also help to dispel harmful stereotypes, myths and misconceptions about mental illness.

While the Nothing to Hide exhibit can be seen in such far-away places as Portland, Oregon, Des Moines, Iowa, and Arlington, Virginia, in the coming months, you don't need to book a flight to see it. Instead, contact Family Diversity Projects at 413-256-0502 or visit their website at www.familydiv.org to request that the exhibit be brought to your school, workplace, conference, hospital or mental health center.

The Changing Minds Bulletin

A publication of the Massachusetts Department of Mental Health, reporting state news and relevant information for clients and their families, mental health professionals, vendors of services, and all citizens interested in the goals and mission of this human service agency.

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Families Speak, Legislators Listen

Early each year, advisory board members, families, consumers, staff and others mingle with legislators over coffee and Danish at the State House and elsewhere to exchange information and ideas. For many, it is a time to get to know one another and learn more about mental illness.

More meaningful than phone messages, e-mails and letters, legislative breakfasts provide a

time to thank legislators and aides for past support, update them on how funds are spent and what they buy in services for people with psychiatric illnesses.

Following opening remarks by DMH Commissioner Marylou Sudders, clients and family members often step to the microphone to tell personal stories about their lifelong journeys of hope. Tragedy,

courage, fear, disbelief, confusion, failure and success: it's all there. And legislators and aides listen, sometimes shaken by what they hear.

Personal accounts come after a recital of facts, figures and reports on the number of residential beds, news of hospital accreditations and data on children's services. Here are excerpts from stories told at this year's legislative breakfasts:

From Dalene Basden, Parent Professional Advocacy League Parent Support Coordinator, who addressed the Northeast Area breakfast. Her son, 14, was diagnosed with Klienfelters Syndrome at age 10:

"I realized my son was different, but I couldn't get any agency to see what I saw. DMH said he isn't crazy enough ... mind you he had just been discharged from psychiatric hospitalization. The Department of Mental Retardation said he wasn't slow enough ... he has a verbal IQ of 43. The school department said he's coming along just fine. He now only spends half the school day under his desk.

"For my family, the bright light was our introduction to wraparound services that are provided through a

DMH contract in the Lynn area. The wraparound process introduced me to all the agencies and service providers at one time. This allowed me to lay out my son's story for everyone to hear and to begin making the connections necessary to get the services he needed. The team meeting did not solve our problems, but it did get us going in the right direction ... Now my son receives the services he needs. He has done very well in a specialized school and we're looking forward to his continuing his education at our local high school."

Basden also spoke of Zachary, a 6-year-old boy, who before receiving wraparound services, had been hospitalized eight times. As a parent coordinator, Basden introduced Zachary's mom to other families with similar needs. They have helped with transportation and respite. Zachary, too, is doing well. Neither he nor his mother, who is also a DMH client, has been hospitalized since wraparound services changed their lives 18 months ago.

And then there is 13-year-old Whitney, whose hospitalizations began when she was 6-years-old. "She has been falling through the cracks ever since," said Basden. Currently in specialized foster care, Whitney is waiting for an intensive residential treatment bed. "We need formal services for these kids" Basden said, "so they can come back to the community better, not just stable." To legislators, she added: "On behalf of all parents with special emotional needs, I ask that you do your part and fund expanded mental health programs for children and adolescents."



January Germano (above), who performed her original composition, Tea for Two, at the Northeast Area legislative breakfast: "And I thought that I was powerless, there was nothing I could do, but each day I grow stronger and I see this isn't true."

From parent Charles Tower, who spoke at the Southeastern Mass. Area breakfast:

"I am the father of a 17-year-old son with a dual diagnosis. Substance abuse issues result from a mental illness believed to be bipolar depression.

"Prior to my son's illness, he was an honor roll student, peer leader, a varsity hockey player and a golfer with a hole-in-one at age 15. That was a little more than a year ago. In the past eight months, my son has had seven hospitalizations in six different hospitals, participated in three outpatient programs and is currently in his fourth residential placement.

"We have been victims of the managed health care system that does not offer patients a continuity of care and services. A suicidal adolescent transported by ambulance to a local hospital must wait several hours to be evaluated by a crisis team. If the crisis team feels the patient meets the criteria for psychiatric hospitalization, the insurance company must approve and the search for a bed spans the state and beyond. We have traveled 73 miles away from our local hospital for an available bed, only to have our son discharged within three to five days with a new diagnosis to add to the list and another medication to try until the next crisis occurs. Then the cycle begins again.

"Desperate for proper treatment, my wife and I were fortunate to have our son evaluated for 30 days by CAP, the Collaborative Assessment Program (run by DMH and DSS) to determine his need for services. After the evaluation, the DMH assigned our son to a case manager to



Charles Tower addresses the Southeastern Area Breakfast.
develop a service plan to provide support and appropriate treatment.

"DMH is able to provide support not only for our son, but for the family as well. The devastating effect of mental illness consumes the entire family. Some of the services include family counseling, home-based support, respite and placement. We now receive support from others in similar situations from PIN, the Parent Information Network.

"There are so many families waiting and in need of services that can be provided through DMH. Too many of our children are "stuck" in the system. With continued support of legislators, mental illness need not be a stigma and our loved ones will get the help they deserve."

Continued on next page



Pauline Couch (left) told Southeastern Mass. Area legislators how her son, Christopher, had attempted suicide before he was 6-years-old. A single mother, with her insurance running out, she called Dan Whelan at the Department of Mental Health. "Since that day our lives have turned around." She credits Chris's case manager, Lorna, who visits home and school "always looking out for Chris's best interests and who has been my lifeline to sanity;" Dr. Alfred Darby, who sees Chris every other week; his therapist, Ginny, whom he sees every week; Dave, his behavioral therapist, who also sees Chris at home and meets with his teachers at school; and Samantha, his "special" who is "God sent" and provides respite care.



From the Cohen family — Ron, Debbie and son, Yoni — who told their stories at the Metro Boston Area legislative breakfast:



Speakers at the Metro Boston Area legislative breakfast, the Cohens: Ron, Yoni, and Debbie embrace.

"I'd like to position what I'm about to say," Ron Cohen told the overflow crowd, "by going back more than 2,000 years ago when the Jewish sages were compiling their magnum opus, the Talmud. They said, *He who saves a single life, it is as if he has saved an entire world.* For any of you who have ever wondered if it is worth all of the time and aggravation, all the headaches, all the setbacks and all of the money, I say to you today, 'yes,' it is worth it." He described the "two horrible illnesses that plague our son, Yoni" - obsessive compulsive-disorder, "where every minute of every day is filled with intrusive thoughts and rituals," and manic depression that caused Yoni to "erupt in uncontrollable rages. The beautiful French doors in our home became nothing more than a target for his anger. Window after window was broken as Yoni smashed his hand or fist through the pane when anger overwhelmed him."

In spite of the "wonderful" help provided by the Brookline public schools, and with his mother giving up her job in nursing to be home full time, Yoni was hospitalized in 1999. After two weeks in the hospital, their insurance company notified the Cohens they would have to take Yoni home. "It was

then," Debbie Cohen said, "we began to despair and finally contacted DMH for services." When case manager Cheryl Murphy asked why DMH had not heard from them earlier, Debbie answered, "We didn't trust anyone to care for him as we could. Also, as Orthodox Jews, we were concerned about the Sabbath and getting Kosher food for Yoni."

Debbie continued, "We needn't have worried." At the Lighthouse, a residential program run by the Home for Little Wanderers, where Yoni is now staying, "the staff goes beyond the call of duty." Their son has been able to come home every Sabbath and the Lighthouse chef, Lonnie, who knew nothing about Kosher food, was so committed to providing Kosher meals, he came in on his days off the first two weeks of Yoni's stay.

Yoni had a simple, but compelling message. "Other kids need to know that they are not alone. When they learn I am succeeding, they will see they can too ... there are nice people who want to help."

"With an overwhelming sense of gratitude and appreciation," Ron Cohen added, "the Lighthouse has saved our lives."

From John Daley, a consumer and Metro Suburban Area board member, who told his story at the State House:

"It is a pleasure and an honor to speak to all of you this morning. Thank you for this opportunity." For his listeners it was an opportunity to hear the remarkable account of a man who first experienced the symptoms of mental illness in 1979. "Auditory hallucinations consisted of voices telling me to hurt myself and others. Unlike the voices you may have in your head about things you need to do today, the voices I hear are different. I describe them as nameless and faceless voices that surround me and chant messages to me over and over again. At the same time, I was struggling with a substance abuse problem."

Daley was living with his parents in Newton and he began to establish "trusting and valuable" relationships with DMH providers. When his parents moved, he chose to stay near his support system in Newton. The following years were not easy for him. "At one point I was homeless, but at a clubhouse I learned about a DMH housing subsidy."



Today, Daley credits the combination of several different services that have helped him reach these goals:

- To be an active member of the Metro Suburban Area board;
- To celebrate his third year of being clean from drugs and alcohol; and
- To be co-president of a DMH consumer-initiative-run business ... where he finds a great deal of pride and reward.

He told the audience, "People who suffer from mental illness need legislators to continue helping us attain affordable housing and ongoing DMH services. I would like to thank the Department for the services I have received throughout the years and also thank the legislators here today for their time and concern for individuals with mental illness."

From Michael McIntosh, who spoke to Western Massachusetts Area legislators in Northampton:

"For 14 years, I struggled with the symptoms of paranoid schizophrenia." Traveling between Boston and Western Massachusetts, Michael recounted how he slept in railway yards and took shelter in abandoned buildings. He ate out of dumpsters, was picked up by the police and was thrown out of the Pine Street Inn, a well-known Boston refuge for homeless people.

While a patient at Northampton State Hospital, Michael started taking medication. After about two months, his psychosis diminished and he was able to start talking to the staff. He knew this was the start of something big — his recovery.

"Today I have a full and often happy life. About four years ago, I married a wonderful woman. Three years ago we bought a house (when interest rates were low) and we took in a disabled man named Charlie to live with us. I know that I was lucky, but my case should be the rule rather than the exception. People took the time and energy to help me and we need to do the same for the other mentally ill individuals out there. Let's show the rest of the country that here in Massachusetts we provide for our mentally ill.

"Thank you for your time and your help."

No one could say it better.

CareVote 2000



Massachusetts Council of Human Service Providers has initiated **CareVote 2000**, a non-partisan voter registration campaign. The goal of the campaign is to register 20,000

individuals statewide from both provider agencies and the disabled consumers they serve.

Co-chaired in the Metro Boston Area by Stan Connors, Executive Director of Bay Cove Human Services, Inc., and Gary Lamson, CEO, Vinfen, Corp., the campaign is being managed by Regional Captains who will contract Area provider staff and consumers.

For more information on voter registration call **1-800-462-VOTE**

Hollywood from page 2

Duckworth is a graduate of the University of Michigan and Temple University School of Medicine. He came to Massachusetts and DMH after exploring options in other parts of the country. He was impressed by the progressive nature of the state and the Massachusetts Mental Health Center (MMHC) when it came to mental health issues.

At the MMHC, Dr. Duckworth applied his extensive clinical expertise in adult, child/adolescent and forensic psychiatry. He was appointed as an adult staff psychiatrist at the center in 1991 and subsequently served as Interim Training Director, Medical Director for Continuing Care Services and most recently as Clinical Director. He has considerable consulting and academic experience, including a teaching position at Harvard Medical School.

While at MMHC, Dr. Duckworth developed the "homeless rotation," where psychiatric residents provide evaluation and treatment in community and traditional settings, including the Cardinal Medeiros Drop-In Center, the Parker Street Women's Shelter and the Committee to End Elder Homelessness. The "homeless rotation" improves mental health care for

homeless mentally ill individuals, making it easier for them to access services. In addition, the program exposes psychiatric residents to the complexities of serving people who are homeless and mentally ill. Some residents associated with the program have continued their work with the homeless after graduation.

As Deputy Commissioner, Dr. Duckworth plans on continuing his work in public education, pointing to the consequences when people with mental illness fail to receive the same level of treatment as those diagnosed with physical illnesses.

In addition, he looks forward to applying his extensive experience with DMH clients at the policy-making level by staying in touch with clients and conducting monthly clinical conferences in each DMH Area. His additional goals include expanding continuity of clinical care and developing guidelines on wellness for people with serious mental illness.

Dr. Duckworth has three children, Megan, 7-years-old, and twins, Katie and Clare, age 3. His wife, Dr. Mary

McCarthy, is the Associate Training Director at Brigham and Women's Hospital in Boston.

Washington from page 2

included a Vermont advocate, who said his state's all-inclusive parity law was the only way to go (he termed the Dominici-Wellstone bill a step sideways); a Delta Airlines human resources director, who spoke of her company's assertive employee assistance program that included treatment for mental illness; and an insurer, who had few reasons for equitable coverage.

Dr. Duckworth provided clinical anecdotes, his perspective on the cost consciousness levels of clinicians in training, and a brief personal account of contrasting coverage of medical illnesses and mental illnesses. He framed the problem in terms of civil rights and argued for intervention at the federal level.

"It was a great way to spend my birthday," Dr. Duckworth said of the experience. More than that, he said, "It was the single most awesome professional experience of my life."

Parity from page 1

medication depleted family savings. To John Willett, "yesterday there was no such thing as mental health parity, Michael's illness was not considered life threatening and hospitalization had to wait on bed availability."

With the recent signing of mental health insurance parity legislation into law by Governor Paul Cellucci, there is the promise of a future free from the fear, stigma, financial and emotional drain that has surrounded the mentally ill and their families. John Willett was on hand when the Governor put pen to paper and made legislation law, with Massachusetts joining 30 other states with parity laws.

Mental health parity eliminates discriminatory insurance coverage practices for the treatment of severe mental illness. As the Governor said when signing the measure, "this abolishes a double standard that has existed in the Commonwealth for far too long."

Many people have a right to bask in the continuous glow of this accomplishment. Many labored behind the scenes delivering a simple yet consistent message: mental illness is an illness, it is treatable and treatment works. Insurance coverage increases the acceptability of the illness and addresses stigma and discrimination so often encountered by individuals and families.

Through the efforts of key legislators, there is reason for renewed hope that beginning January 1, mental health insurance parity will right a historic wrong in Massachusetts.

The law provides full mental health insurance benefits for children, adolescents under 19, and adults who have biologically based brain disorders such as schizophrenia, mental illness and bipolar disorders. In addition, insurers are required to



provide a minimum of 60 days of inpatient care and 24 outpatient visits for non-biologically based disorders, such as adjustment disorders.

Neuropsychological assessments and psychopharmacological services will be covered in full and will not be counted as part of the 24 outpatient visits.

The new benefits also will cover individuals with mental illness and co-occurring substance abuse disorders. The law provides insurers with the same access to mental health records as they have to all other medical records. It requires consent of the insured or covered family member before patient information may be disclosed. Only licensed mental health professionals may deny services.

As the Governor noted at the May 2 signing ceremony, estimates have placed the cost of the

added benefit at about 1%. "That's a pretty small price to pay for enhancing the lives of thousands of citizens. There is a cost to it, but it is one that as a society we should be willing to bear. More importantly, mental health insurance parity is the right thing to do," he said.

Facts have not supported predictions of staggering commercial premium rate increases in other states. An actuarial analysis done on previous parity legislation in Massachusetts shows net employer contributions rising about \$1.41 per member per month.

The Commonwealth's Group Insurance Commission (GIC) currently requires HMOs covering state employees to provide equitable coverage for treatment of mental illness and physical ailments. The GIC action, taken a year ago, had little impact on rates. In the future, the federal government will require parity in the coverage of 9 million federal employees through 285 private insurance plans.

I am working with Insurance Commissioner Linda Ruthardt to prepare for implementation for health insurance plans covering more than 50 employees. This includes commercial insurers, nonprofit hospital service corporations, medical service corporations and health maintenance organizations.

Mental health remains in the shadows of health care, but the new law will bring mental illness into the light by eliminating the financial barriers to accessing treatment. It has been worth the fight.

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Changing Minds Bulletin

The Massachusetts Department of Mental Health

Vol. 1 No. 20 Fall/Winter 2000



From the Commissioner

Interagency Initiative Targets Child-Adolescent Mental Health Crisis

By Marylou Sudders

There is a crisis in mental health care for children and adolescents in Massachusetts. This is not a revelation; I first publicly outlined it 18 months ago when the usual seasonal decline in hospitalizations failed to materialize. The problems we see today of emotionally disturbed kids in hospital beds who could be better served with intensive wrap-around services or in secure behavioral intensive residential treatment programs and community residential settings did not surface yesterday. They have been building for some time and quick fixes don't provide long-term solutions in such cases. There are no easy-to-implement, off-the-shelf remedies.

This does not mean it is an unsolvable problem. The people charged with coming up with answers have been working diligently with the unified purpose of providing necessary and appropriate post-hospitalization services to move children through a system of care to recovery. And the same people from child-serving agencies are working just as hard to come up with ways to deal with a child's disorder before it becomes a crisis.

There is resolve in attacking the immediate problem of kids waiting in emergency

rooms for treatment of psychiatric disorders and moving others who are clinically ready out of acute psychiatric hospital beds and into residential treatment. A \$10 million appropriation in this fiscal year's budget is funding two new 15-bed secure behavioral intensive residential treatment programs at Westboro and Tewksbury State Hospitals for adolescents with serious mental health needs in the custody of the Department of Social Services (DSS). Fifteen more DSS-involved kids awaiting hospital discharge and deemed appropriate to receive intensive community mental health services at home or in specialized foster care have been identified. They are being matched with services tailored to their needs.

DMH also is adding more than 45 residential slots throughout its system by expanding intensive residential treatment programs and increasing community residential capacity. The funding will also increase the child psychiatry time available to each of the six DMH Areas, and provide for Clinical Care Coordinators in each of the DSS regions, who will facilitate the discharge of DSS children and work with

Initiative continued on page 11



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“Quality of Life” Is in the Eye of the Beholder

“People with serious and persistent mental illness want exactly the same things we do,” Dr. Robert Goisman told a recent gathering of clinicians, consumers and advocates. The Harvard Medical School professor and keynote speaker at a “Quality of Life” seminar called the topic a subjective concept, not easily determined by observation and not always related to severity of psychiatric symptoms.

A sense of well being includes the need for basics such as stable housing, satisfying work, rewarding relationships and enjoyable leisure activities, he said. He singled out good family relationships as the most important factor affecting a mentally ill person’s life. Contrary to conventional thinking, less restrictive settings ranging from state hospitals, to group homes, to supervised apartment living seem to have little impact on a person’s perception of a fulfilling life, Dr. Goisman said, although to be homeless and mentally ill leaves little expectation for a favorable “quality of life.”

For those with mental illness, a top quality of life issue revolves around the stigma associated with psychiatric disorders. Despite recent research in understanding the brain and availability of new and more effective treatments, individuals with mental illness still suffer from stigma and discrimination. What their fellow citizens may take for granted – personal safety, access to social security benefits and even to general health care – are, for them, sometimes obstacles to a good life.

It was not until the advent of new antipsychotic medications, particularly clozaril, that “quality of life” became part of the discussion for many patients diagnosed with a mental illness. It took on a new meaning: How satisfying is a person’s life, not how ill the person is. With new medications offering more benign side-effect profiles and as good or better benefits, “quality of life” began to mean not merely a reduction of symptoms, but an “ethical duty of psychiatric treatment,” Dr. Goisman said.

Dr. Alan Green, Director of the Commonwealth Research Center, a Harvard Medical School administered

DMH research program, agreed. The novel antipsychotics “changed the face of schizophrenia in the same way Prozac changed the face of depression,” he said. Green said that the new treatments also appear to help control substance abuse, improve negative symptoms (lack of motivation and enjoyment) and limit suicide that occurs in 10% of patients with schizophrenia, all contributing to the likelihood of a better quality of life.



To explain how the new medications work, Dr. Green described the neurobiological foundation of psychosis (the areas of the brain affected) and the way chemical substances (both legal and illegal) affect the brain. With medicines having less toxic side-effects and more hopeful outcomes, Dr. Green suggested that early intervention for first episode psychosis is now a more attractive treatment option. A study of first episode schizophrenia is underway at the research and evaluation unit at the Lindemann Mental Health Center in Boston. In addition, there are studies comparing clozaril to standard treatment and to olanzapine, medications prescribed to combat schizophrenia. Studies include a full medical and psychiatric evaluation while participants remain in the care of their current clinicians. All studies look at the effects of investigational medications on “quality of life” and ability to function.



Dr. Green was optimistic, predicting that newer and more effective medications combined with therapy will continue to change the face of these disabling disorders. Within five years, medications will not only control symptoms (delusions and hallucinations), but improve cognitive function, the part of the brain that organizes thoughts.

Larry Seidman, Ph.D., Director of the Neuropsychology Laboratory at the Massachusetts Mental Health Center, also struck an optimistic note with the news that cognitive deficits do not worsen over time in schizophrenia and may even improve. Seidman said that in the past 20 years, studies have indicated that schizophrenia is a brain disorder and that today we can expect “improvement in cognitive function to be a treatment goal.”

Just as meaningful work matters to the general population, it has an impact on people with mental illness. Kim Mucser, Ph.D., Professor of Psychiatry at Dartmouth Medical

Life continued on page 10



Fear and Stigma: Hurdle for Parents with Mental Illness

Larry Stier is a parent with mental illness. He is a loving and capable father, but he lives with the stigma of his illness every day. When he has questions or needs assistance with parenting, he feels too vulnerable to reach out and ask for help. He is afraid his child will be taken away.

Stier is not alone in his fear. Stigma is a barrier to service utilization for many parents with mental illness. In some states, a psychiatric disorder justifies the removal of children from parents, the termination of parental rights and loss of custody. Like many parents, those with a mental illness also worry about health care, finances, childcare, housing and the general happiness of their children.

Most state mental health systems offer few, if any, services to parents with mental illness. However, the gap is being closed on some fronts with innovative studies, programs and policies.

The federal Center for Mental Health Services (CMHS) sponsored a study conducted by Kathleen Biebel, M.S., of the Center for Mental Health Services Research. The 1999 survey focused on the responses of 50 state mental health agencies to adult clients who are parents. The findings were troubling. Of the mental health agencies surveyed, only 24% routinely identify adult clients as parents, 22% assess adult clients' functioning as parents, 27% provide services related to parenting, and 8% have policies regarding adult clients and parenting.

A group of researchers, providers and advocates recently spent two days discussing how to offer appropriate services and how to educate the courts, state agencies and the public to the needs of parents with mental illness. Joanne Nicholson, Ph.D., of the University of Massachusetts Medical School, moderated the forum. She also presented her preliminary findings from a national

survey of program directors. She again found few programs offering services designed specifically for families with a mentally ill parent. She did find 65 programs targeted to other groups; families with a mentally ill parent participated.

The initial survey has lead to the next phase in the study that includes: the development of a National Advisory Group on Parents with Psychiatric Disorders and Their Families; the development of site visit protocols; five site visits of programs across the country; and the preparation of a final report regarding "best practice."

One of the innovative programs discussed was the Parenting Options Project, sponsored by DMH and the Center for Mental Health Services Research at the University of Massachusetts Medical School. It is one of the few programs targeting people who need parenting services. The program provides technical assistance in developing programs and has created a parent needs assessment form as a way for agencies to determine the needs of parents with mental illness.

Vicki Cowling, who is conducting seminars concerning programs and initiatives, relayed her experiences. She has found that wherever she goes, she encounters the same issue: lack of services for parents with mental illness. Cowling has authored a book entitled, "Children of Parents with Mental Illness." In the book, Cowling states that parents with mental illness have the same hopes and aspirations as other families, but they are often stymied because mental illness is still misunderstood and services do not yet function in a way that satisfies their needs.

At the conclusion of the two-day discussion, the message was clear: the service and support needs of parents with mental illness must be addressed. In order to achieve this goal, the service paradigm should be shifted from

With a Little Help, People with Mental Illness Sharpen Parenting Skills

The complex nature of family relationships that challenges society is elevated by chronic, stigmatizing mental illness. In the past, when a person was discharged from a psychiatric hospital, the question was, who in the family would provide care? Never asked was the question, would the person discharged be providing care for others? The proposition of adults with mental illness raising children was never considered.

Those attending a recent "Quality of Life" conference looked into the family functioning unit within the world of mental illness in presentations by Joanne Nicholson, Ph.D., Associate Director of the Family Center Project at UMass Medical School, Susan Chase, a parent and DMH client, and Patricia Sannicandro, a family member.

Nicholson rendered a historic perspective on how the mental health community viewed the family role and how mentally ill mothers were treated. In the early part of the 20th century, Nicholson said that women with mental illness were often sterilized. Later, institutionalized women were brought to state hospitals to deliver their babies. In Massachusetts, many women had their

Skills continued on page 9



Fear continued on Page 9



DMH VIDEO LIBRARY: NOW PLAYING

Clinicians! Consumers! Advocacy Groups! Educators! Legislators!

The Department's office of public affairs has a varied selection of videos. Some are personal stories, others include reports that have aired on 60 Minutes, Nightline and HBO. They provide a valuable addition to group therapy discussions, family support meetings, clinical training sessions and as a source of information about the much misunderstood subject of mental illness. To receive a list of available videos, please call 617-626-8157. Videos are mailed free of charge and are due back in two weeks.



New additions to the library include:



"Day For Night ~ Recognizing Teenage Depression"

A look at the signs, symptoms and treatment of teenage depression and includes interviews with teens diagnosed with depression or bipolar disorder.

Kay Redfield Jamison, Ph.D., professor of psychiatry at Johns Hopkins School of Medicine, says of this film, "The kids are just terrific, what a wonderful film to do – gutsy and genuinely helpful to other kids and I hope to parents as well."



"I Love You Like Crazy ~ Being a Parent with Mental Illness"

Eight mothers and fathers who have mental illness talk about their sense of helplessness and apparent invisibility to well-meaning social and legal systems. They express their grief, but also their courage.

"By their very example, they help to destigmatize mental illness for all of us." Kayla Bernheim, Ph.D., psychologist and author.



"Unlabeled"

This film documents how individuals with mental illness have taken charge of their lives and how their leadership is transforming needs into a growing social, political and human rights movement.



"Invisible Workforce"

Employers, job developers and DMH clients tell their experiences and offer suggestions to help others achieve success in the workplace. (19 min.) "The greatest strength of this video is that it shows the desire and ability of people with mental illness to succeed in real-world employment." Otto Wahl, author of *Telling is Risky Business: Mental Health Consumers Confront Stigma*.



"Stigma"

Interviews with people from the mental health and substance abuse communities in Maryland: consumers, families, providers, educators and administrators. Created by the anti-stigma project, "On Our Own," and funded by the Center for Mental Health Services, SAMSHA and the Department of Health and Human Services. Booklet on stigma, with discussion questions. Resource guide and bibliography included.



"Trapped Within"

Courageous patients share the dread and terror of obsessive compulsive disorder, a brain chemistry phenomenon that affects 1 in 40 Americans. Researchers and therapists describe effective new treatments and medications (56 minutes).



"On Our Way to Understanding"

Consumers and staff of the Point After Club, members of the Greater Lawrence Area Site Board and clinicians explain the experience and stigma of mental illness. An interview with Dr. Ken Duckworth, DMH Deputy Director of Clinical and Professional Services, defines stigma and its impact. Given four stars by viewers at the Tri-City Mental Health Center day program in Malden, Massachusetts (30 minutes).



"Back From Madness"

Follows four psychiatric patients for one to two years from the time they arrive at Massachusetts General Hospital. Rare archival footage demonstrates how their conditions were treated in the past and examines what psychiatric treatment is like today. Used as a teaching tool at Harvard Medical School.

COMMONWEALTH CONNECTIONS

First Major Change in 30 Years Alters Involuntary Commitment Law

On November 11, 2000, Massachusetts put into effect a law that strengthens patients' rights, and, says DMH Commissioner Marylou Sudders, "reflects advances in clinical practice." Under the new law, the time for involuntary hospitalization has been reduced from 10 to 4 business days and the time for a requested hearing has been reduced from 14 to 4 business days. If a person feels the commitment is an abuse of the law, a hearing will be held that day or the next business day.

Patients must be notified of their right to have a court appointed attorney and quarterly reports on these reforms must be submitted by the Department of Mental Health to the House and Senate Committees on Ways and Means and to the Joint Committee on Human Services and Elderly Affairs. "The intent of the legislation is to put more power into the hands of people who have been involuntarily hospitalized and I endorse this development," said Dr. Ken Duckworth, DMH Deputy Commissioner of Clinical and Professional Services.

In addition, DMH regulations now ensure that the most qualified physicians will render an assessment of the need for involuntary emergency hospitalization. Believing that the best balance of civil rights and medical necessity requires the direct involvement of a psychiatrist, the regulations have defined as "designated physicians" those doctors who may make determinations of commitment.

Previously, waivers were granted in extenuating circumstances allowing non-psychiatrist physicians with three years experience on staff at a psychiatric facility to be "designated physicians." These general waivers expired January 1, 2001. To meet the new requirements, each licensed facility must have on staff or through a contract, a complement of physicians able to conduct "immediate" examinations (within two hours) for authorization of admission on a 24-hours-a-day, seven-days-a-week basis.

At all facilities, a roster of designated physicians must be in place and available for monitoring by January 1, 2001. "Compliance with the designated physicians requirements," says Commissioner Sudders, "is particularly important in protecting the interests of both patients and facilities in light of the mandates of the recently changed civil commitment law."

DMH Offers Harvard Medical Students Unique Learning Experience

The past decade's drop in the number and length of in-patient stays at psychiatric hospitals has affected medical students' traditional experience of psychiatry rotations. Today's system provides fewer opportunities to

learn about the wide array of mental illnesses and observe patients' progress and responses to the range of current treatments.

At a meeting of the Association of Directors of Medical Student Education in Psychiatry (ADMESP), Robert Goisman, M.D., director of residency training at the Massachusetts Mental Health Center, described the unique clerkship offered by Harvard Medical School. Students spend a month at the center's day hospital assigned to a multidisciplinary team where they are introduced to individual and group therapy, cognitive-behavioral therapy, family interventions and psychopharmacology.

Even students who are not planning to specialize in psychiatry find it rewarding. "The program is a nice marriage between the goals of psychiatry and those of a general medical education," said Dr. Goisman. ♦



The Changing Minds Bulletin

A publication of the Massachusetts Department of Mental Health, reporting state news and relevant information for clients and their families, mental health professionals, vendors of services, and all citizens interested in the goals and mission of this human service agency.

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DMH Honors Employees...



Candice L. Page

Eleven individuals, the Worcester State Hospital and Central Massachusetts Area staffs, the Pocasset Mental Health Center maintenance crew, the Intensive Stabilization and Treatment Program at Medfield State Hospital, and team leaders from the Assaulted Staff Action Program and the Human Resources Compensation Management System were recently recognized for outstanding job performance at a special Performance Recognition Awards dinner at the Hynes Convention Center in Boston. Governor Paul Cellucci delivered the keynote address.

Commonwealth Citations for Outstanding Performance were awarded



John E. Arruda



Jose Tosado and Gail Haggerty



Ekaterini Poulakos



Worcester State Hospital and Central Massachusetts Area staffs



Assaulted Staff Action Program

...at Performance Recognition Ceremonies

to DMH employees and programs demonstrating exemplary performance in the workplace. Award winners helped the Department attain high priority agency objectives, demonstrated organizational, managerial, or communications skills, showed exemplary leadership and contributed toward making significant improvements in productivity or realizing savings in agency operations. They were honored by Commissioner Sudders at a reception before the dinner.



Medfield Intensive Stabilization and Treatment staff



The maintenance crew of the Pocasset Mental Health Center



Ruth L. Kingston



Norma J. Yeary



Vishakha Mehta



Teresa J. Reynolds



Human Resources Compensation Management System

Americans, the Media and Mental Illness

Three quarters of the American population, across all demographic segments, report that in the past six months they have seen something about mental illness in the news. They recalled information, not just about mental illness in general, but a majority said they were aware that mental illness comprises a range of disorders, including depression, schizophrenia and obsessive compulsive disorders.

Based on a survey of more than 1,000 Americans, the National Mental Health Association found both good and bad news. Most people believe that media coverage has improved public understanding of mental illness and although they now think treatment and medications can help people to recover, half said they saw psychiatrists and mental health professionals as "manipulative, quacks, interested primarily in money or power." A majority

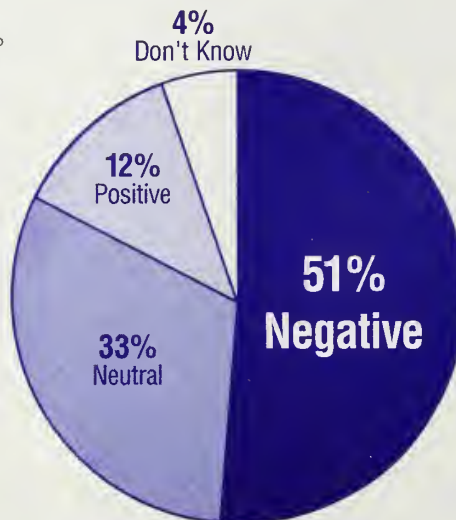
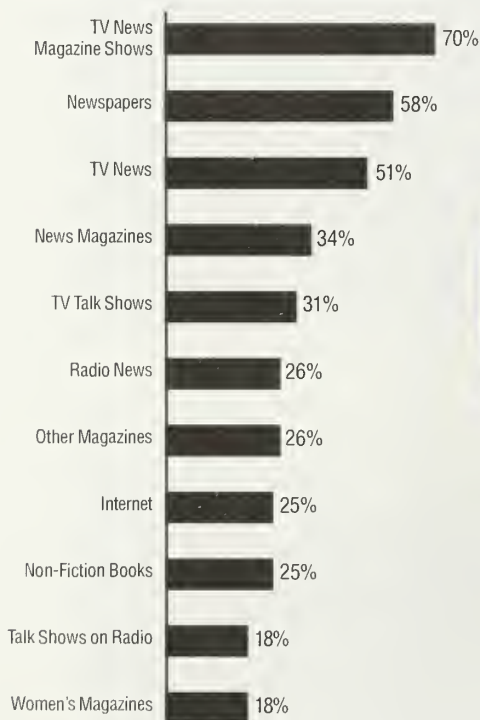
(57%) said they knew someone who has been diagnosed as having a mental illness.

Why does all this matter? Because the "national spotlight" can go a long way in raising both awareness and money. A successful film or a front page story influences the public's perception of the causes, outcomes and costs of illness. The mental health community does well to monitor the media for fairness and accuracy.

Stigma Matters: Assessing the Media's Impact on Public Perception of Mental Illness

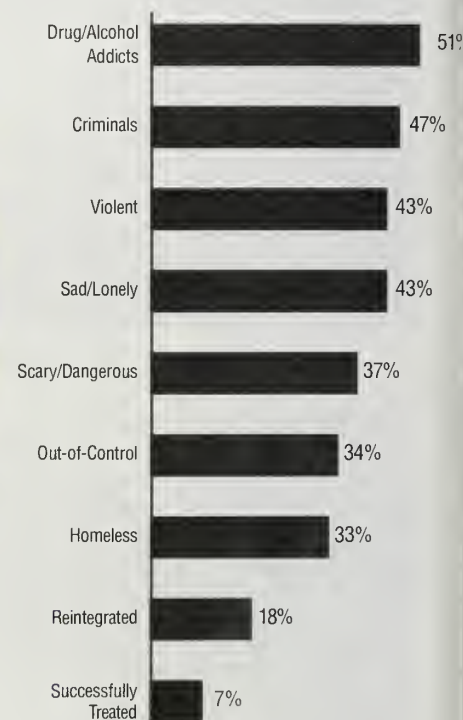
We Asked Americans: How Do You Think People with Mental Illness Are Shown in TV and Movies?

Top Information Sources for Mental Illness



Based on a survey of 1,022 adults in April 2000 for the National Mental Health Association

Americans Say People with Mental Illness Are Often Portrayed in TV and Movies as:



Fear from page 3

individual adults and children to families. The discussion was only the first step in addressing the stigma associated with being a parent with mental illness and in guaranteeing appropriate services.

The forum provided an opportunity for others to share research, policy and program information within Massachusetts and with other

states. Included in the group were: Zvi D. Gellis, Assistant Professor, and Lynn Videka-Sherman, Professor, State University of New York at Albany; Nancy Rollins, Director, New Hampshire Department of Children, Youth and Family; Linda Thomas, Children's Services Coordinator NAMI, New Hampshire; and Vicki Cowling, visiting from the Maroondah Hospital for Child and Adolescent Mental Health Services

in Victoria, Australia. DMH staff included: Barbara Fenby, Metro Suburban Area Deputy Area Director; Dr. Thomas Horn, Central Massachusetts Area Medical Director; Joan Kerzner, Director of Policy Development, Central Office; Richard Breault, Assistant Director of Child and Adolescent Services in the Central Massachusetts Area; and Ann Capoccia, Child and Adolescent Division, Central Office. ♦

Skills from page 3

newborn at Worcester State Hospital where evidence of early delivery rooms still exists. At birth, a baby was immediately taken from its mother and brought to the hospital nursery. Mother returned to the institution from which she came and her baby stayed at the hospital. Many babies remained as long as two years until they were adopted or other care arrangements made.

Citing a national study, Nicholson said that 68% of women with psychiatric disorders are mothers and 48% of their children have psychiatric disorders. Nicholson dubbed this a "Family Event." Mothers with mental illness generally receive little help and guidance with parenting skills, Nicholson noted. "Parents' Projects," funded by SAMHSA, (Substance Abuse and Mental Health Administration) with support from DMH and the University of Massachusetts Medical School, is helping to address this long neglected service gap. Over the past several years, "Projects" has developed an education and skills training program for parents with mental illness. It developed a National Advisory Group on Parents with Mental Illness that convened at the National Institute of Health in Bethesda, Maryland, in October 1999 and its research has shown the significant value of supporting all family members in understanding and coping with the impact of mental illness.

Susan Chase, who has experienced mental illness as a daughter and a mother, has traveled the long road to recovery. Today, she lives with her son and better understands her mother. She has found medication that addresses her needs and work she enjoys. She singled out the staff of Employment Options, a Marlboro-based clubhouse that provides supports for mentally ill par-

ents, for helping her to realize the life she wanted. What she once thought of as a "system," is now the reach of helping hands. "We don't need systems," she said. "We need people."

Speaking from her experience as a mother whose son, the youngest of five children, has schizophrenia, Patricia Sannicandro took attentive listeners along on her son's arduous journey to recovery. She said that each family member has walked in her son's shoes on the way to the better "quality of life" he now enjoys.

Misunderstanding and alienation from his siblings left this youth's parents alone and frightened. Mrs. Sannicandro said that care in The Bridge of Central Massachusetts often went "over and above" her expectations. The years brought hospitalizations, alcohol abuse and many disappointing failures, but the people at The Bridge never gave up. "They are overworked. There are not enough of them. They are all angels," she said.

She had one piece of advice and one wish for families. The advice: do not go into denial; the wish: that one day, families will not have to be advocates. The Family Center Project is working to bring that day closer.

(For more information on Parents' Projects, contact Joanne Nicholson, Ph.D., Associate Professor of Psychiatry, University of Massachusetts Medical School, Worcester, MA 01655. Telephone: 508-856-8712.) ♦

Boston, Site for Surgeon General's Public Hearing on Suicide Prevention Strategy

The hearing that took place on November 2, 2000, at the JFK Federal Building was one of several held around the country by Surgeon General Dr. David Satcher to improve knowledge about suicide, to determine ways to prevent it and to develop measures to put these practices to work. Commissioner Sudders and DPH Commissioner

THE FACTS

- More than 30,000 Americans commit suicide each year.
- The suicide rate is five times the number of homicides.
- Suicide is the third leading cause of death for people between the ages of 15 and 24.
- A half-million people attempt suicide each year, but survive.

Dr. Howard Koh testified at the emotional, all-day, standing-room-only hearing.

Family members who had lost loved ones to suicide lent their voices to Dr. Satcher's effort to combat suicide as a public health problem. They called for effective preventive measures and all participants (parents, children and siblings) said they believed greater awareness and less stigma would be good starting points.

Crisis Link, a group like Samaritans, based in Washington, has a new national number, 1-800-SUICIDE. ♦

Life from page 2

School, said, "people who work don't get worse and people who work improve." Although most individuals with serious mental illness want to work, employment rates are typically low, ranging between 10% to 20% of the population. Supported employment programs have been developed to address the gap.

Programs in Massachusetts, such as DMH's Services for Employment and Education (SEE), and Employment Options, a clubhouse program in Marlboro, prove that employment training does work and that honoring individual preferences results in more satisfaction and longer work histories. Dr. Marie Hobart, Chief Medical Officer and Director of Clinical and Professional Services at Community Healthlink in Worcester, noted that "people can change...it is always possible." She urged clinicians to assume that individuals are able to make changes with support.

Overall health depends, in part, on good medical care, but some internists have trouble treating people with mental illness because psychiatric disorders may have an impact on medical judgment, said Dr. David Hermann of Beth Israel/Deaconess Medical Center and an instructor at Harvard Medical School. When psychiatric patients perceive they are being treated differently, it is not paranoia. It is real, a point also made by Dr. Ken Duckworth, Deputy Commissioner of Clinical and Professional Services at the Department of Mental Health.

Dr. Hermann offered tips on how to facilitate medical appointments for consumers, offering common sense suggestions about insurance forms and referrals, even role-playing to reduce stress and anxiety for the patient.

For the homeless, even the best systems do not always work. Barbara Blakeney, R.N., Director of Homeless Services of the Boston Public Health

Commission, said, "a Nobel discharge plan is useless to the homeless." Drug and alcohol use is so pervasive in this group that treatment must be integrated. "The system has not yet done that," said Blakeney. What comes first, mental illness or drug abuse, should not be a concern.

"I want to treat both concurrently and successfully."

Using baseball as a metaphor, she said it used to be that the psychiatrist did the pitching, the nurse did the catching and the client was battling against the whole team. The family was not even in the game. Now the consumer is pitching and the entire team, including family members and consumers, is battling the psychosis.

As for "quality of life," a trusting relationship is still the key. Blakeney believes that not only family and friends, but staff, including non-clinical staff, provide it. A bridge is built by relationships, "wherever you can find them."

The two-day conference was sponsored by the Department of Mental Health, the Commonwealth Research Center, Harvard Medical School, and the University of Massachusetts Medical School. ♦

**"People who
work don't
get worse
and people
who work
improve."**

Initiative from page 1

DMH and providers to assure clinical continuity.

This will help alleviate problems at the front door of hospitals. It presumes that appropriate staffing can be hired for every bed put on line. Time has taught us that prosperous economic times work against human service providers. Experience tells us that staffing is usually available for 7 of every 10 new residential beds. The hope is that staffing for all of the expanded residential components will be available.

Having outlined the short-term plan, let me point out that this is not just a public problem. Many parents with family medical insurance plans look to the same hospital beds when sons and daughters need this level of treatment. While inpatient expansion has occurred with the addition of licensed beds over the last five years, it hasn't kept pace with demand. Compounding the problem is the fact that the other New England states lack inpatient and residential capacity. In a free-market economy, they look at Massachusetts to help fill their needs.

The nationwide shortage of child psychiatrists means that some children wait longer than they should for medication and therapy. Very few doctors are going into child psychiatry training programs. This is true in the Commonwealth as well. As one child psychiatrist recently said, "Sometimes, it feels like I'm the only game in town." But more child psychiatrists won't necessarily solve this problem. Clinicians must be part of parents' health insurance plans and it can be difficult to come up with the right therapist-child fit.

Simply adding acute inpatient capacity alone will not solve the prob-

lem. The Massachusetts Behavioral Health Partnership, which is responsible for the network of child/adolescent acute hospital beds under a contract with the Division of Medical Assistance, has increased capacity by 132 beds since April 1999. But some children still wait to be hospitalized. If even more hospital beds are put on line, they will be filled.

The beds already added have reduced the time children wait for an appropriate placement. In May, only one-third of children under DSS

**If even more
hospital beds
are put on
line, they will
be filled.**

care were discharged from hospitals within 30 days. By August, that had nearly doubled to 62%.

The costs of inaction would be staggering, since we are in the midst of a 10-year, 24% increase in the number of adolescents. This means a potential increase of 9,000 Massachusetts children with mental illness and emotional disturbance at the end of the cycle. The Department's last field reports show 2,497 children awaiting case management, the glue for kids and families and our safety net in keeping children out of hospitals by lining up school-based services, respite care and after-school programs that supplement therapy. During the last fiscal year, DMH provided case management to 1,898 kids, up from 1,469 two years earlier.

Building post-hospitalization residential capacity is a must. Expanding superb community and outpatient care to identify kids with mental illness before a crisis sends them to the emergency room and to deal with their after-care once the crisis has passed is essential. As of October 1, Massachusetts increased the payment rates by 8.25% for all outpatient providers and raised the rate for psychiatric hospitalization 11%. Medicaid increases will cost \$15 million this fiscal year and \$20 million in FY2002.

As you can see, the public sector is responding. A concerted effort is underway to minimize the number of children not in appropriate care. The private sector must match these efforts. The advent of mental health insurance parity in January provides a piece of the solution. In part, the mandate calls for insurers to pay for unlimited outpatient visits for children under age 19, if their disorders are even at risk of interfering with normal cognitive and social development.

Parity will help. The blending of resources in a structured, cohesive manner also will help to better pinpoint children at risk of mental illness at an earlier age and provide services needed to avoid the trip to an emergency room. Should hospitalization be necessary, quality care will foster moving clinically ready children to the next level of care and through the mental health system.

There is little disagreement about what we are looking at. There is an understanding about the measures needed to get the mental health care system for kids flowing again. We are moving in the right direction. ♦

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FROM THE COMMISSIONER

Latest DMH Study Suggests People With Mental Illness at Higher Risk of Early Death

BY MARYLOU SUDDERS

Consumers, providers and advocates have long been aware that people with mental illness carry a double burden – not only are they stigmatized by their mental illness, they also face a higher risk of an early death from health problems particular to people with mental illness. The concern is real, but challenging to address, mainly because of the lack of statistics – until now.

Studying mortality is one way to learn about cause and effect in the realm of health care and DMH historically has issued such reports on its population. Research and data among our consumers, however, have been based on an age-adjusted model used in standard populations. In statewide mortality studies, for instance, two important elements are infant mortality and the deaths of individuals over age 75. Since DMH clients include no infants and few over age 75, age-adjusted rates limit how we can understand deaths in DMH. The latest study completed in June by the department, Mortality Report 1998-1999, breaks new ground by collecting age-specific data and confirming what

we have known anecdotally – people with mental illness die younger than their nondisabled counterparts and they die of illnesses we don't expect people that age to die of.

One of the most striking findings of this study is that DMH clients age 25 to 54 die of cardiac problems as much as seven times more than that of the general population. Lung disease was also two to six times more problematic as a cause of death for DMH clients in the 25 to 64 age bracket than for their counterparts in the general population. Since DMH clients are as a group much younger than that of the Commonwealth, it is disturbing to find such an excess of deaths from these two medical conditions, deaths that are more typical in older people.

Under the supervision of Ken Duckworth, M.D., Deputy Commissioner of Clinical and Professional Services, the department forged this new ground and is committed to remain on the forefront nationally in developing rigorous, data-driven analyses of the medical and psychiatric needs of its clients. By being

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THE FACES OF

Annual Legislative
Breakfasts are forums for
sharing stories, instilling
hope for recovery

STIGMA

Every year in February, the Department of Mental Health hosts a series of Legislative Breakfasts where constituents and their families, as well as citizen advisory board members, staff and providers meet. The occasion provides an opportunity to thank legislators for their past support, to update them on how funds are being spent, and to outline the Governor's budget proposal for services.

As in the past, the North East Area kicked off the series in the Great Hall, followed by areas in Southeastern Massachusetts, Metro Suburban and Metro Boston. Central and Western Massachusetts Area breakfasts were held in Worcester and Northampton.

The impact of past legislative breakfasts was most evident in the passage last year of insurance parity legislation; \$10 million in expansion funding for children's services; \$1.9 million to address adult residential needs; \$1.8 million to insure appropriate administration of medication to children and adolescents in residential programs; and \$1 million for continued expansion of services to the homeless mentally ill.

The true centerpiece of the breakfasts occurs when consumers and fam-



CYNTHIA FERREIRA

ily members step to the microphone to tell their own stories, stories that are a mix of fears and heartache, hopes and successes. Following are a number of excerpts from these stories. They help to put a face on mental illness, demonstrate that treatment works, remind us that stigma is pervasive and must be eliminated. They ask all of us to join in celebrating the power of hope and recovery.

Jails No Place for the Mentally Ill

Bonnie DeRosa reminded her listeners of the dark days, not so long ago, when her brother first became ill, when her family was in "perpetual pain without a glimmer of hope." In the 1980s, she said, "there

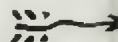
were no clubhouses, no ACT programs or anti-stigma campaigns. It was the role and obligation of each family to act as psychiatrist, case manager and sometimes, police."

Although today, Bonnie's brother is on medication, *medication that is monitored*, she noted that there are still far too many casualties in the mental health system. DeRosa thanked Marylou Sudders, "a strong commissioner," and those decision makers who vote for a decent and fair budget and understand that "jails are not where the mentally ill belong."

Finding His Way

Steven Doyle's life "began to spin out of control" at age four

Continued on next page



Dorothy McMorrow, the mother of an individual with mental illness, describes what parents feel when they learn their child is mentally ill.



Continued from previous page

After two hospitalizations, placement at a residential school, stays at Phoenix House and a foster home, Steven began attending Dearborn Academy and later graduated as an Honor Roll student from Stoneham High School. He now works in the field of computers and informational technologies and thanked "caseworkers, doctors, programs and all the dedicated people, especially my family, who helped me find a path when I could not feel ground beneath my feet."

Peer Education and Roads to Recovery

When Jo-Ellen Stone's father, Harold, committed suicide 42 years ago, there were no answers and no supports for his widow and three small children. Jo-Ellen's mother had never even heard of mental illness.

Twenty years later, Jo-Ellen and her brother began to exhibit some of their father's strange behaviors, the symptoms of his undiagnosed, untreated bipolar illness.

By then, there was NAMI (National Association for the Mentally Ill,) an advocacy group of families helping each other to cope. The Stone's involvement with NAMI led to Moe and Naomi Armstrong and to the Peer Educators Project.

Today, Jo-Ellen helps lead workshops at Westboro State Hospital called Roads to Recovery.

"Both my family and the mental health system have come a long way in 42 years, but we still have a way to go," she said. "Our job is not finished until all of us — consumers, family members, providers, state officials and



Deborah Szalno speaks about her son Matt's six-month wait for a Children's Intensive Residential Treatment Program placement and how that placement changed Matt's and his family's lives.

representatives — work together to make sure that every person in our state gets the mental health services that they need."

It Takes a Team Called PACT: Program for Assertive Community Treatment

As a mother of a son living with schizophrenia, Mary Verdella-Nelson described David "as a bright toddler, sociable school boy, energetic ice hockey, basketball and chess player, paperboy, self-motivated student, college graduate and his family's pride!"

When David was "struck down, in spite of a joyful upbringing, a full education and loving family," what did it take to lift the darkness? "It took a whole TEAM," his mother said, "a case coordinator, clinical staff, nurses, housing and substance abuse specialists — an ACT (Assertive Community Treatment) Team — a new program model in Massachusetts." David was

the Lowell ACT team's first client. ACT is producing amazing results for clients at risk and costs less than a group home, Verdella-Nelson told the audience.

For the blessing of ACT, "David, his dad, mother and sister are rescued," she said. "I pray we keep moving ahead, for all the Davids still out there."

Mt. Vernon Street Project in Fitchburg

The father of a son with schizophrenia and long-time advocate, Nelson Goguen, brought to the legislators news of the Mt. Vernon Street Project in Fitchburg. This HUD 811 funded housing, now nearing completion will provide three apartments for four individuals. An unusually small venture for HUD which prefers a larger number of units, this plan creates a homelike, non-institutional atmosphere. Funds have been allocated to provide services for one homeless individual whose new address will be 25 Mt. Vernon Street.

Goguen concluded with his thanks to the legislature for their assistance in addressing the homeless problem and with a quotation from Franklin Delano Roosevelt: "*The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough to those who have little.*"

Clubhouse Housing Works!

At the age of 19, Maria Marsh was a substance abuser just released from a treatment facility whose mother would

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not allow her to return home. That was the beginning of a series of stays at homeless shelters, even during her first semester at a prestigious college in Boston.

"You might think that money allotted to supported housing programs is a waste. I am here to say it is not," Marsh told the legislators gathered at Worcester State Hospital for the Central Massachusetts breakfast. "What Genesis Clubhouse did was help me break the cycle of hospitalization and homeless shelters." Breaking this cycle saves taxpayers money and helped Maria Marsh "find a place I could call home."

Stigma is Real

"How could this be and how did it happen?" asked the dad whose son wished him to remain anonymous. "Severely depressed, abusing alcohol, making multiple suicide attempts, completely out of control" is how this father described the "normal, happy kid who had done well in school and excelled in sports." Advised that unless their son received appropriate treatment, he would either go to jail or die, his parents sought legal custody and a safe, secure school setting.

Appalled at the meager insurance coverage for psychiatric care, this dad borrowed from his company, from his boss and from his 401K fund. He told of other families who obtained new credit cards with maximum cash advances just to pay for some services for their children.

"The most important and surprising part of the family's journey was the role of DMH," he said. Unlike what they had anticipated, they found "tremendous care and professional-

ism" in respite care, an invaluable case worker, an in-home care worker and an intense residential placement that probably saved my son's life."

For all this, he gave thanks to the people who rescued them and to the legislators who make these kinds of services possible.

Recovery Means Freedom

For Dan Martin, recovery gives him a feeling of independence that he did not have when his psychiatric disability took over his life. The onset of his illness began while he was in college and ultimately forced him to drop out. No longer able to work or go to school, he became homeless, lived on the streets, had a series of state hospitalizations and struggled with medication. Once approved for Department of Mental Health Services, he found the road back to better health.

"I did not know what freedom and independence was until my illness took them away from me. It is difficult for people to understand the many obstacles that stand in the way if you are ill — to function from day-to-day and the courage and fortitude it takes to face each day."

Lawmakers gathered in the Great Hall at the State House to hear DMH consumers and family members tell their stories of success, hope and dreams during the department's annual series of Legislative Breakfasts.

Dan saw the light at the end of the tunnel when DMH stepped in. "I was given outpatient services, residential care, employment and case management. All of these services led to many days of personal success."

Success at Corrigan Mental Health Center: From Patient to Staff Member

Cynthia Ferreira's mental illness has caused her life to look a little like a roller coaster. Before she was diagnosed with severe depression and delusional thinking, she worked in a nursing home as a nurse's aide. But after having what she calls "a nervous breakdown," it was Cynthia who needed care. After a few hospitalizations Cynthia became an outpatient at Corrigan Mental Health Center and became active in a local DMH supported clubhouse program, Towne House.

"Towne House was a great part of my life. I felt like I belonged somewhere and was a part of something constructive. Now I have a part-time job with Corrigan as an office assistant. You can imagine what it feels like to be a worker instead of a patient."





THE

CUBAN

EXPERIENCE

A visit with the man who transformed the Cuban mental health system from one of the worst to among the most innovative

Naomi Pinson and I went to Cuba in January of 2000. We met different people from the Cuban mental health system. This is the story of one special encounter.

Naomi and I were taken to the Psychiatric Hospital of Habana. This is a large hospital on the outside of Habana. At the hospital we met Dr. Eduardo Ordaz. Dr. Ordaz had been a soldier during the Revolution with President Fidel Castro. He was one of the original commanders or, *commandantes*, from the days of 1957 to 1959. After the success of the Cuban Revolution, Castro asked Dr. Ordaz to turn around the Cuban mental health system.

The Cuban mental health system had been one of the worst in the world. More than 3,000 people were crammed into one small space. In some cases, 200 people were living and sleeping in one room at time. There was dirt and filth everywhere. The people who were at the mental hospital were ridiculed and scorned by the people of Habana.

Dr. Ordaz came to the hospital and established mental health care that was clean, safe and humane. He developed the book *Ethical Principles and Regulations Regarding the Attention to the Mentally Ill*, which was published and followed all through Cuba. A program of psychiatric rehabilitation was put in place at the hospital.

People were able to learn transferable work skills while they were at that hospital. They have workshops that teach people how to refinish furniture, make commercial art crafts, do office paperwork, and go back to the jobs they had in town. In Cuba, it is against the law to lose your job because you become mentally ill. The hospital has an entire return to work program. This program also teaches employers about the person who will be returning to work and their psychiatric condition.

By Moe Armstrong

The hospital has a whole outreach component which then works with people to help keep them sane and stable in the community. This outreach component is housed at the hospital but travels through Habana to see that people are doing well after discharge. The hospital also has a variety of day programs which people can attend. For example, they have one program just about music where people are trained to be musicians and give professional musical performances. They are trained in both classical and popular music styles.

Naomi and I saw a performance of the students of this musical school. The performance was more than two hours long and Dr. Ordaz stayed with us during the performance. Before the revolution, Dr. Ordaz had also been a professional classical musi-

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CULTURAL COMPETENCE...



"The message of cultural competence is difficult to get across, even to the good guys," said Terry Cross, executive director of the National Indian Child Welfare Association and keynote speaker at the Department of Mental Health Second Annual Multicultural Conference held on June 7 at the Wyndham Westborough. Nearly 300 mental health clinicians, administrators and advocates gathered to hear Cross and a number of distinguished faculty who held workshops on subjects ranging from cross-cultural pharmacology to culturally competent forensic mental health services. A center-



Top Left: Rev. Frederick J. Streets, Yale University chaplain, converses with Deborah Scott, DMH Assistant Commissioner for Forensic Mental Health; Top Right: Michele Klopner, PsyD, Richard Mollica, MD, were members of a plenary panel that discussed a broad range of topics from culturally competent research to every applications in clinical settings; Right: Keynote speaker Terry Cross, MSW, ACSW, LCSW, in his presentation explained how cultural competence directly relates to Maslow's Hierarchy of Need.



FROM 'WHY' TO 'HOW'

piece of the event was the official public presentation of the department's Cultural Competence Action Plan, the product of lengthy and intense work by staff across all disciplines throughout the state. The Action Plan covers the areas of community inclusion, services, human resources, education and training, data and research and information. Co-sponsoring the conference with the Office of Multicultural Affairs was the University of Massachusetts Medical School Department of Psychiatry and Office of Continuing Education.



Top right: Venerable Khon Sao, head monk at the Triratana Buddhist Temple in North Chelmsford greets workshop participants with his assistant; Above left: Terry Cross discusses diversity with DMH Chief of Staff Marilyn Berner; Above right: Featured at the conference was a photo exhibit by Marcus Halevi called "Courage and Resiliency: Cambodian Women in America," inspired by oral histories conducted by the Harvard Program in Refugee Trauma; Left: Attendees prepare for the keynote address

Empowering Families Through Peer Education

"Transforming Families From Personal Devastation to Action and Power," presented by Joyce Burland, Ph.D., developer and director, Family to Family Program, was held this spring through a grant from the Department of Mental Health in cooperation with the Massachusetts chapter of the National Alliance for the Mentally Ill (NAMI-MASS). The 12-week course graduated participants in Andover, Bedford, Fitchburg, Haverhill, Holyoke, Hyannis, North Adams, Pittsfield, Plymouth, Taunton, Wakefield and Worcester.

Taught by trained family members, the curriculum covered schizophrenia, bipolar disorder, manic depression, clinical depression, panic disorder and obsessive-compulsive disorder, basing its teachings on the knowledge and skills that family members need to cope more effectively.

Over the course of the program, small classes of about 20 people gathered in meeting rooms provided by organizations such as churches, public libraries and local colleges. There, family members began to understand their own traumatic experiences as well as that of their relative with mental illness. Encouraged to recognize their anger and confusion over the stigma and discrimination they have encountered and armed with current knowledge about the neurobiological aspects of brain disorders, the program shows the way to a life perspective that allows for self-care and empathic support of the mentally-ill family member.

Class members often went on to join advocacy efforts

for better services and increased awareness of mental illnesses. "Family to Family" courses are taught in 36 states and several provinces of Canada. In the past five years, more than 35,000 people have taken the course. The program is scheduled to run again this fall in Massachusetts with the following scheduled dates:

Lexington: starting September 4, from 7 – 9 p.m. *Contact Pat or Alan Wood at 781-862-0008.*

Waltham: starting September 5, 7 – 9 p.m. *Contact Rita Sagalyn at 978-371-4904 or Chris Gilmartin at 617-373-4449.*

BEYOND FAMILY TO FAMILY

Also with DMH funding, NAMI-MASS and its co-sponsor, the Parent Professional Advocacy League, will be rolling out the first set of "Visions for Tomorrow" courses, also scheduled this fall. Designed for families and caregivers, course topics include: bipolar disorder, brain biology, depression; conduct disorder; anxiety disorders, obsessive-compulsive disorders, post-traumatic stress disorders, ADD/ADHD, phobias and childhood psychosis. Classes will also cover: parents as case managers, communication skills, coping, rehabilitation, recovery and stigma.

For more information call Anne Khudari, program director at 781-938-4048 or e-mail Anne at akf2f@yahoo.com.

Study from page 1

more sophisticated in our information gathering and the continued study of deaths among DMH clients, we expect to identify whether greater susceptibility to medical illness is mostly correlated with risk factors such as smoking or poverty, or whether something specific in the development or treatment of chronic mental illness leads to increased mortality.

As a result of this report, DMH, in collaboration with other state agencies, including the Division of

Medical Assistance and the Department of Public Health, will develop best practice guidelines for medical care for people with chronic mental illness. Already, interagency projects are underway. Among them:

- ◆ to improve access and continuity in medical care
- ◆ to enhance communication among behavioral and health care providers
- ◆ to promote prevention strate-

gies such as smoking cessation and adult immunization

- ◆ to expand early detection of diseases

Through interagency collaboration and participation in the Massachusetts Medical Society's Patient Safety Initiatives, DMH is also working to protect patient safety with projects directed at reducing medication errors and the potential toxic effects of drug interactions and at increasing education regarding suicide risk assessment and suicide prevention.

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cian. He personally works in designing and teaching the musical program in this part of the hospital.

We were also shown a baseball diamond at the hospital. Cuba wouldn't be Cuba without baseball. The hospital has a couple of baseball teams. Also, teams from Habana come to play baseball at the medium-sized stadium so that families can come from Habana to see their family members play baseball. Exercise and good nutrition are incorporated in all programs. Here, physical health is seen as important as mental health.

Dr. Ordaz showed us the places where arts and crafts are made. He took us to the retail store where Naomi and I bought some of these creations to take home.

Everywhere we went, Dr. Ordaz was loved and cheered. People came up to him, cried and hugged him. People at the hospital felt that coming to the facility was an opportunity to get sane and stable. People were able to get back to work and live their lives.

The problem that they have at the hospital is access to medicine. Cuba has an economic blockade against it. Cuba cannot get the psychiatric medication that they need. The only medicine they are able to get is Haldol. And then, sometimes they have Haldol and sometimes they don't. They have tried Risperdol with great success. Risperdol is only sent to Cuba if a

family member is able to send medicine from the United States, Canada or Europe.

When people run out of medicine, they are given a space to live until they can get medication. Some people have 90-day hospitalizations from this lack of medication. They have to stay as an inpatient with no medication. I couldn't imagine the pain this must bring to the patient.

I also found it strange that almost all the patients like their medications and wanted to stay on them, yet they couldn't get access to new medications. Or sometimes, they couldn't get access to any medication.

Patients in Cuba depend on a huge and very complete system of mental health care. Medication is only one part. Dr. Ordaz spends a great deal of personal time with his patients. There are teams of social workers, nurses, doctors and direct care workers employed in the Cuban mental health system. Mental health is part of the national health care benefit and services available for everyone. There are clinics all through Habana that deliver mental health care to people.

The doctors at the area hospitals are the same doctors who go into the community. Imagine your psychiatrist paying you a house call. That's how it is in Cuba. Each person is then tracked and their highest human potential developed by the same doctor. Psychiatric rehabilitation is part of all treatment.

Dr. Ordaz talked about his dream of having many people return to the community and live with out returning for hospital care. He said that 60 percent of people who have gone through the state hospital system have gone out into the community and never returned to the hospital. This is probably because Cuba has invested a great of time and money into early intervention and out-patient care. There is ongoing follow-up and a lifetime commitment to community day programs after the person leaves the hospital. Access to mental health care is part of Cuban citizenship.

Dr. Ordaz expressed interest in peer support models and we told him about the Peer Educator Project, which promotes people with mental illness as a resource, and together we can learn from each other. "Reach One - Teach One" is the motto of the Peer Education Project.

We explained to Dr. Ordaz that from this, people go on to be part of the National Alliance of Mentally Ill (NAMI) or other ex-patient organizations. People in this project have also gone on to become skilled mental health workers

We look forward to working with Dr. Ordaz in the building of a Peer Educator Project and a NAMI affiliate in Cuba. Naomi Pinson and myself are making plans for our next trip to Cuba to spend more time with *Commandante* and the wonderful system of mental health care that he has constructed. ✱

Collaborating for Suicide Prevention

The state departments of Public Health and Mental Health have together made suicide prevention a priority as DPH Commissioner Dr. Howard K. Koh and DMH Commissioner Marylou Sudders work to enlist support and collaboration on statewide suicide prevention strategy.

Alarming findings from the Surgeon General's national report on suicide and a recent DPH study for Massachusetts clearly demonstrates that suicide is a serious public health problem — in 1998 alone, more people in the Commonwealth died from suicide (503) than from either homicide (123) or motor vehicle accidents (471).

Following the recommendations of the Surgeon General's "Call to Action to Prevent Suicide," Commissioners Koh and Sudders have sent letters to state agencies in the human services, education, health and law enforcement sectors, asking for representatives from each agency to join a coalescing working group that began meeting in June.

"The Massachusetts Departments of Public Health and Mental Health have been working with the Massachusetts Violence Prevention Task Force in the formation of the Massachusetts Suicide Prevention Working Group," the letter states. "This group of state and local health and safety officials, private sector professionals and advocates have been working together to address the problem of suicide in our state."

The goal of the Suicide Prevention Working Group is to have a draft of a statewide prevention plan by the end of this year.

"This is a multi-dimensional issue that will require all of us to work together — youth, elders, police, health workers, everyone," said Greg Miller,

executive director of the Samaritans of Merrimack Valley and co-chairman of the Working Group. "Some state agencies are involved, but we need to get a lot of other agencies on board to help with the work we're doing."

Part of that work is increasing public awareness. On May 9, the Suicide Prevention Working Group sponsored Suicide Prevention Awareness Day in the

Great Hall at the State House. In solemn symbolism, dozens of vases packed with hundreds of bright irises decorated the dais, but not to mark the spring season. Instead, each flower represented every suicide death in the U.S. in the past year, a striking visual representation of the severity of suicide in the United States.

Commissioner Sudders, a keynote speaker at the event, told guests that national data puts suicide as the eighth leading cause of death.

"If statistics paint a picture and capture the magnitude of the problem," Commissioner Sudders said, "then we must remember that during the course of this two-hour event today, there were at least 120 suicide attempts and at least eight lives lost to families and loved ones by suicide."

**For information about
the Suicide Prevention
Working Group, call
Ellen Connorton at the
Department of Public
Health
617-624-5433**

The CHANGING MINDS Bulletin

is a publication of the Massachusetts Department of Mental Health, reporting news and relevant information for clients and their families, mental health professionals, vendors of services and all citizens interested in the goals and mission of this human service agency.

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Looking Ahead Toward a New

MASSACHUSETTS MENTAL HEALTH CENTER

The Department of Mental Health (DMH) is proposing a unique public-private partnership initiative for redeveloping the Massachusetts Mental Health Center (MMHC), a facility with an enduring reputation for research, training and clinical excellence in the community mental health field. Located on a three-acre campus in Boston's Longwood medical area, MMHC provides vital services for people with serious mental illness in the Metro Boston Area through a broad array of community mental health programs. In addition, it is a major research and training site for Harvard Medical School.

Sadly, MMHC's physical plant at 74 Fenwood Road has not kept pace with the program changes that have made the facility an historic leader in mental health services. DMH occupies four structures on the property, totaling 189,000 square feet of space. The earliest structure was built in 1912 and now, all four buildings are in poor condition.

In addition to excessive leaks, flooding and persistent air ventilation problems, the facility lacks accessibility under the Americans with Disabilities Act.

Renovation estimates developed by the Division of Capital Asset Management in 1990 placed the cost of such rehabilitation at more than \$58 million. In today's dollars, the price tag is considerably higher.

Dating back to the Center's inception in 1912, training and research activities flourished largely due to a longstanding relationship between the Commonwealth and Harvard Medical School.

Because of this relationship and the facility's unparalleled standing in the mental health field, a previous effort to vacate and close MMHC was vehemently opposed. As recently as 1994, legislative intervention stopped any plans to close the facility. In the past three years, the department has been engaged in a process promoting an open dialogue among the key stakeholders involved with MMHC. Clients, family members, staff, academicians, lawmakers and other constituents have, in the course of this open discussion, given their input and from this have delineated what steps need to be taken to retain the facility's clinical, research and training programs while addressing the realities of a

crumbling physical plant.

On June 7, the fruits of this open process were presented to the Massachusetts Mental Health Center Advisory Board. The DMH proposes that the three-acre MMHC campus be developed by a successful bidder via a long-term lease arrangement with the Commonwealth. In exchange for this lease, the ground lessee would be obligated to develop a new MMHC facility, including a day hospital and transition shelter. These facilities would be built at no cost to the Commonwealth and in exchange, the ground lessee would have rights to develop the remainder of the site for their own purposes.

A preliminary study commissioned by DMH confirms that there is significant interest among the Longwood Area health providers in this valuable parcel and that this project would be economically feasible for a prospective developer. This anticipated integration of the Massachusetts Mental Health Center with its Longwood Area neighbors would complement our efforts to destigmatize mental health treatment and put this critical service on par with the delivery of physical health care.

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